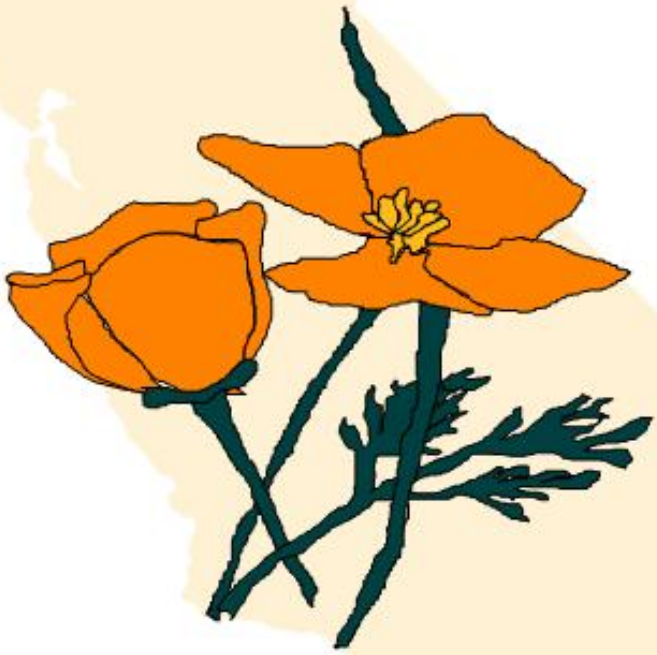
Tuberculosis Registry Guidelines

June 2006



California Department of Health Services
Tuberculosis Control Branch

What's New in Version 2.0

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Welcome

Welcome to tuberculosis case reporting and the TB Registry Guidelines in PDF format, Version 2.0 - June, 2006. *"A guide to tuberculosis reporting and services in California*" (See What's New in Version 2.0)

We have compiled these instructions to provide you with the information you will need to successfully count and report cases of tuberculosis to the **Tuberculosis Control Branch, California Department of Health Services**.

To strengthen the accuracy of TB reports and to improve the usefulness of the registry data, we occasionally need to review and revise TB reporting protocols. Also, new guidelines are developed as the need arises. We will make new versions of the Tuberculosis Registry Guidelines available as necessary.

We hope these Guidelines prove to be a useful tool for tuberculosis case reporting in California. To begin, please see **RVCT Report - Form Completion Instructions** for detailed information and instructions on how to fill out the RVCT, Follow-Up 1, and Follow-Up 2 reports.

Contact Information

The Tuberculosis Registry Guidelines are a service of the:

California Department of Health Services, Division of Communicable Disease Control, Tuberculosis Control Branch

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TB Surveillance Report Forms in PDF Format for Viewing and Printing

You can acquire printable PDF versions of TB Surveillance reports from the following locations:

TB Registry Guidelines Help: The **TB Registry Guidelines Help system** is provided on the CD distributed by the TB Registry. The Help system contains all TB surveillance forms in PDF format for the following reports and services: *RVCT, Follow-Up 1 and 2, ARPE, A/B-Notification, Contact Investigation Toolkit, Genotyping, MDR-TB, Outbreak, Patient Locating Service*.

To receive your copy of the CD or to receive the Help system by email, please contact Bill Elms at the TB Registry welms@dhs.ca.gov.

TBCB Web Site: http://www.dhs.ca.gov/ps/dcdc/TBCB/index.html (forms will be available on the website in late 2005).

TB Registry: To receive forms by email or USPS, contact Bill Elms at the TB Registry welms@dhs.ca.gov.

To view and print the PDF forms, you will need the Adobe Acrobat Reader installed on your local system. If you do not have it, you can download it for free by going to **http://www.adobe.com/products/acrobat/readstep2.html**.

Support

TBCB support policy for TB Registry users

The TB Registry Help Desk is available for questions concerning RVCT and Follow Up Report completion, case counting, report submission, and the use of this Help system.

Hours of operation:

8 am - 4 pm, Monday - Friday, excluding holidays

Telephone: Jennifer Allen, Tuberculosis Registry Surveillance Associate (510) 620-3026

FAX: (510) 620-3035

Email: TBregistry@dhs.ca.gov

For questions or problems that occur outside the office hours specified above, please leave a telephone or email message and a TB Registry staff will contact you as soon as possible.

Before you contact TB Registry Support:

- See if you can find the answer to your question in this Help system. To find what you're looking for, you can look up topics in the Contents, and search for keywords in the Index.
- If you suspect that the problem may be in your local system, consult your LHJ technical support representative, your manager, or other LHJ staff, as appropriate. If others have experienced the same problem, they may have the answer or answers you're seeking.

Privacy Policy

TB Registry Guidelines Privacy Policy for case/patient identifiers, and other confidential data: The following privacy declaration is printed at the bottom of the paper forms for the RVCT report supplied by the CDC and the CDHS-TBCB. It also applies to the online forms that you may use, view, print, or download from this Help system.

Privacy declaration for RVCT, Follow Up 1, and Follow Up 2 reports

Information contained on this form [RVCT, Follow-Up 1, Follow-Up 2] which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

References

The following list provides references for case counting and patient designation definitions.

1. Recommendations for Counting Reported TB Cases. Atlanta: CDC, January 1977.
2. CDC. Case definitions for infectious conditions under public health surveillance. MMWR 1997;46(no.RR-10):40-41. (http://www.cdc.gov/epo/dphsi/casedef/)
3. Technical Instructions for Medical Examination of Aliens. Atlanta: CDC, Division of Quarantine, revised July 13, 1992.
4. Statistical Yearbook of the Immigration and Naturalization Service, 1994. Washington, DC: US Department of Justice, Immigration and Naturalization Service, 1995.

Resources

Following are a few frequently used Tuberculosis resource links that you may find useful. Please note that the Web links in this topic were verified as valid at the publication date of this Help system. There is no guarantee that they are still valid at the time of your use.

For additional resources links, please visit the TBCB website at:
http://www.dhs.ca.gov/ps/dcdc/TBCB/index.html

TB Resource links

California Tuberculosis Controllers Association http://www.ctca.org/ (includes local contact information)

National Tuberculosis Controllers Association http://www.ntca-tb.org/

The Frances J. Curry National Tuberculosis Center http://www.nationaltbcenter.edu/

CDC Division of Tuberculosis Elimination http://www.cdc.gov/nchstp/tb/default.htm

What's New in TB Registry Guidelines Version 2.0, June 2006?

This section provides a list of additions and changes to Version 2.0 of the TB Registry Guidelines in Help and PDF format.

Note: Please note that the Data Dictionary, RVCT report forms with field names, and the Anatomic Code spreadsheet can only be downloaded from the **Help** system. The **TB Registry Guidelines Help system Version 2.0** is available on a CD or by email from the TB Registry. If you don't have a copy of the Help system on your local computer, please contact the TB Registry at: tbregistry@dhs.ca.gov.

New features in both the TB Registry Guidelines PDF manual and the Help system:

- **Anatomic Code Instructions**: Improved instructions for assigning anatomic codes in Questions 15, 16, 19, and 20. See Appendix A - Anatomic Codes for RVCT Questions Q 15 and Q 16 and Anatomic Codes for RVCT Questions Q 19 and Q 20.
- **Q 09 Race HL7 Codes**: Added a list of HL7 Race Specify Codes used in Q 09 Race for specifying Asian and Native Hawaiian or Pacific Islander.
- **Notice on California SB699**: Information about new HIV and AIDS confidentiality regulations as a result of the passage of California SB699.
- **ICE**: Updated contact information for U.S. Immigration and Customs Enforcement (the topic describes transfer protocols for TB patients detained by ICE).
- **Country Code list**: Updated Country Code list.
- **Definitions**: Added definition for Class B2 Tuberculosis to the A/B-Notification topic and to the Glossary. Added Glossary definition for LHD and updated the definition for LHJ.

New features only available in the TB Registry Guidelines Help System

The Help system contains all of the new features and changes included in the PDF manual plus the following topics and downloadable files:

- **Anatomic Code Spreadsheet**: An Excel spreadsheet that you can download. The spreadsheet shows the relationship between anatomic code entires for Q15, 16, 19, and 20.
- **Verification Criteria**: A technical description of the RVCT verification algorithm used by TIMS to verify a case of Tuberculosis. See the Verification (vercrit) Calculation for TB Cases topic.
- **Data Dictionary**: The TB Registry Data Dictionary is a tool for Local Health Jurisdictions interested in examining data exported from TIMS. The data dictionary includes field names pertaining to the RVCT, Follow-up 1 and Follow-up 2 Reports, calculated variables (definition), and control flags for identification of unknown dates (field name + "unk"). See the TB Registry Data Dictionary topic.
- **RVCT and Follow-Up forms with field codes**: Data Dictionary information also includes downloadable PDF forms with field code overlays. These forms may be used in conjunction with the Data Dictionary as tools for data analysis. See Forms_with Field_Names section in the TB Registry Data Dictionary topic.
- **FAQs and Common Errors**: The FAQs and Common Errors topic provides some answers to your "frequently asked questions (FAQs)" about entering data in the RVCT report, and also gives you some helpful hints for avoiding common errors.
- **Patient Locating Services**: Updated information and contacts for the Patient Locating Service.
- **Outbreak**: Updated information and contacts for the TB Outbreak Service.
- **Genotyping**: Updated information, spreadsheet, and contacts for the TB Genotyping Service.

Recommendations for Counting Reported Tuberculosis Cases

Recommendations for Counting Reported Tuberculosis Cases

This topic provides recommendations for counting TB cases for inclusion in the annual DHS-TBCB morbidity report.

The information in this topic is based on the **California** February 1998 edition of *Recommendations for Counting Reported Tuberculosis Cases*, it updates and supersedes all previous versions prior to 1998.

Note: A distinction should be made between *reporting* TB cases to a health department and *counting* TB cases for determining incidence of disease. Throughout each year, TB cases and suspected cases are reported to public health authorities by sources such as clinics, hospitals, laboratories, and health care providers. From these reports, the state or local TB control officer must determine which cases meet the current surveillance definition for TB disease. These verified TB cases are then counted and reported to the Centers for Disease Control and Prevention (*CDC*).

Topic contents:

Reporting TB Cases

CDC recommends that health care providers and laboratories be required to report all TB cases or suspected cases to state and local health departments based on the current *Case Definition for Public Health Surveillance* (*reference 2*). This notification is essential in order for TB programs to:

- Ensure case supervision
- Ensure completion of appropriate therapy
- Ensure completion of timely contact investigations
- Evaluate program effectiveness
- Assess trends and characteristics of TB morbidity

TB Surveillance

For the purpose of surveillance, a case of TB is defined on the basis of laboratory and/or clinical evidence of active disease due to M. tuberculosis complex. When there is insufficient laboratory evidence, clinical evidence alone can be used to count a case of active TB.

Note: The three mycobacterial species of *Mycobacterium tuberculosis complex (M. tuberculosis complex)* are M. tuberculosis, M. bovis, and M. africanum. Disease caused by any of the three organisms should be reported as TB.

Laboratory Case Definition

- **Isolation of M. tuberculosis complex from a clinical specimen**. The use of rapid-identification techniques for M. tuberculosis performed on a culture from a clinical specimen, such as DNA probes and high-pressure liquid chromatography (HPLC), is acceptable under this criterion.

OR

- **Demonstration of M. tuberculosis from a clinical specimen by nucleic acid amplification (NAA) test**. For surveillance purposes, California Department of Health Services will accept results obtained from NAA tests that are approved by the Food and Drug Administration (FDA) and used according to the approved product labeling on the package insert.
- **NAA tests must be accompanied by mycobacterial cultures**. If the cultures are negative for M. tuberculosis, a positive NAA by itself does not meet the laboratory case definition. However, if the culture results are unknown (or if cultures are contaminated) but the NAA test is positive, a laboratory case definition is permissible.

Note: Current FDA-approved NAA tests are only approved for use on smear-positive respiratory specimens from patients who have received no antituberculous therapy, less than 7 days of such therapy, or have not received such therapy in the last 12 months. However, because these instructions may change with modifications to the NAA tests, package inserts should be referred to with each use.

OR

- **Demonstration of acid-fast bacilli (AFB) in a clinical specimen** when a culture has not been or cannot be obtained; historically this criterion has been most commonly used to diagnose TB in the postmortem setting.

Clinical Case Definition

In the absence of laboratory confirmation of M. tuberculosis complex after a diagnostic process has been completed, persons must have all of the following criteria for clinical TB:

- Evidence of TB infection based on a positive tuberculin skin test

Note: Because HIV-infected persons frequently have false-negative tuberculin skin test results, the criterion of positive tuberculin skin test is not required as part of the clinical case definition in these individuals.

AND

- One of the following:
  - Clinical evidence of active TB (e.g., fever, night sweats, cough, weight loss, hemoptysis), or
  - Abnormal, unstable (worsening or improving) chest radiograph, compatible with current TB disease.

AND

- Current treatment with two or more anti-TB medications

Important: The case definition described herein was developed for use in this topic and is not intended to replace the case definition for TB as stated in the current *Case Definitions for Infectious Conditions Under Public Health Surveillance* *(reference 2)*.

Vercrit and Provider Diagnosis: In addition, the software for TB surveillance developed by CDC includes a calculated variable called "Vercrit," for which two of the values are "Clinical Case Definition" and "Provider Diagnosis". "Provider Diagnosis" is selected when the user chooses to override a "Suspect" default value in the case verification page as "Verified by Provider Diagnosis." Although "Provider Diagnosis" is not a component of the case definition for TB in the current "Case Definitions for Infectious Conditions Under Public Health Surveillance" publication, CDC's national morbidity reports have traditionally counted cases in this category even though they do not meet the published case definition.

In the software for TB surveillance, the "Clinical Case Definition" value for the "Vercrit" variable can only be selected when a case has a positive tuberculin skin test. Therefore even though CDHS recognizes an HIV-infected individual may be a clinically confirmed case when the tuberculin skin test is negative, such an individual can only be given a "Provider Diagnosis" in the surveillance software of CDC.

Counting TB Cases

Note: Cases that meet the current CDC surveillance case definition for verified TB are counted by 52 reporting areas with count authority (50 states, District of Columbia, and New York City) to determine annual incidence for the United States. The remaining 7 reporting areas (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, Republic of Palau, and the U.S. Virgin Islands) report cases to the CDC but are not included in the annual incidence for the United States. Laboratory and clinical case definitions are the two primary diagnostic categories used by the CDC *Case Definitions for Infectious Conditions Under Public Health Surveillance*.

- Most verified TB cases are accepted for counting based on laboratory confirmation of M. tuberculosis complex from a clinical specimen.
- A person may have more than one discrete (separate and distinct) episode of TB. If disease recurs in a person within any 12-consecutive-month period, count only one episode as a case for that year. However, if TB disease recurs in a person, and if more than 12 months have elapsed since the person was discharged from or lost to supervision, the TB is considered a separate episode and should be counted as a new case.
- Mycobacterial diseases other than those caused by M. tuberculosis complex should not be counted in TB morbidity statistics unless there is concurrent TB.

Verified TB Cases

COUNT

- Count only verified TB cases that meet the laboratory and/or clinical case definition. When there is insufficient laboratory evidence to confirm disease, clinical evidence alone can be used to count active TB. A case of TB must be verified by the TB control officer or designee. The current CDC surveillance case definition for TB describes and defines the criteria to be used in the case definition for TB disease.

DO NOT COUNT

- If diagnostic procedures have not been completed, do not count; wait for confirmation of disease. Do not count a case for which two or more anti-TB medications have been prescribed for preventive therapy, or while the diagnosis is still pending.
- Do not count cases with a laboratory diagnosis of M. tuberculosis complex when false-positive laboratory results are known to have occurred. For example, laboratory cross-contamination is frequently responsible for these false-positive results.

Nontuberculous Mycobacterial Diseases (NTM)

COUNT

- An episode of TB disease diagnosed concurrently with another nontuberculous mycobacterial disease should be counted as a TB case.

DO NOT COUNT

- Disease attributed to or caused by nontuberculous mycobacteria alone should not be counted as a TB case.

TB Cases Reported at Death

COUNT

- TB cases first reported to the health department at the time of a person's death are counted as incident cases provided that the person had current disease at the time of death. The TB control officer should verify the diagnosis of TB.

DO NOT COUNT

- Do not count as a case of TB if there is no evidence of current disease at the time of death or at autopsy.

Immigrants, Refugees, Aliens (regardless of residency status), Border Crossers, and Foreign Visitors

COUNT

Immigrants and refugees who have been screened overseas for TB and

- have been classified as Class B (B1, B2, or B3). (See A/B-Notification.)
- are examined after arriving in the United States and diagnosed with clinically active TB requiring anti-TB medications, and
- have not been started on anti-TB medications for treatment of tuberculosis outside the U.S. (This criterion does not need to be met in cases where there is laboratory confirmation of Mycobacterium tuberculosis in the U.S.)
- should be counted by the jurisdiction of their usual residence at the time of diagnosis.

  Usual residence: the place the patient was living at the time of diagnosis. This may be the place the patient receives mail (not a P.O. box), pays an electric bill, or considers to be his primary, stable residence in the U.S. The jurisdiction of a state, federal or military correctional facility where a patient was diagnosed with TB should be considered the usual residence of that case.

  Time of diagnosis: the date the first specimen was collected from the patient or, if no specimen was obtained, the date the first diagnostic test (e.g., chest x-ray) was performed. This applies even if the first specimen collected from the patient does not meet the laboratory criteria for disease. If no specimen was collected, and no diagnostic tests were done, the date treatment was started can be used as the time of diagnosis.

Aliens (regardless of residency status) who

- are examined and diagnosed with clinically active TB in the U.S.
- have not been started on anti-TB medications for treatment of tuberculosis outside the U.S.
- should be counted by the jurisdiction of their usual residence at the time of diagnosis.

Border crossers who

- are examined and diagnosed with clinically active TB in the U.S.
- have not been started on anti-TB medications for treatment of tuberculosis outside of the U.S., and
- plan to receive anti-TB therapy from a jurisdiction in the U.S. for 90 days or more
- should be counted by the jurisdiction that diagnosed the case.


Note: Border crosser: defined, in part, by the Immigration and Naturalization Service (INS)4 as "a nonresident alien entering the United States across the Mexican border for stays of no more than 72 hours." Border crossers may go back and forth across the border many times in a short period.

Foreign visitors (e.g., students, commercial representatives, and diplomatic personnel) who

- are examined and diagnosed with clinically active TB in the U.S.
- have not been started on anti-TB medications for treatment of tuberculosis outside of the U.S., and
- plan to receive anti-TB therapy from a jurisdiction in the U.S. for 90 days or more
- should be counted by the jurisdiction that diagnosed the case.

DO NOT COUNT

- TB cases in immigrants or refugees who have been classified as Class A with a waiver (TB, infectious, "Noncommunicable for travel purposes") should not be counted as new cases even if the persons receive routine initial work-ups in the United States.
- TB in persons who are temporarily (<90 days) in the United States, for whom therapy may have been started but who plan to return to their native country to continue therapy, should not be counted in the United States.

Out-of-State or Out-of-Area Residents

COUNT

- If a patient is diagnosed with TB while away from their usual residence for less than 90 days, the case should be counted by the jurisdiction of their usual residence at the time of diagnosis. If a patient is diagnosed with TB while away from their usual residence for 90 days or more, the case should be counted by the jurisdiction that diagnosed the case.
- If the usual residence of a patient is in a state other than California, the TB control officer should notify the appropriate out-of-state TB control officer of the person's home locality to (1) determine whether the case has already been counted to avoid "double counting," and (2) agree on which TB control office should count the case if it has not yet been counted.

DO NOT COUNT

- Do not count a case in a newly diagnosed TB patient who is an out-of-area resident and whose TB has already been counted by the out-of-area TB control office.

Migrants and Other Transients

COUNT

- Persons who permanently reside in the U.S. but do not have a fixed U.S. residence are considered to be the public health responsibility of their present locality and their TB case should be counted by the jurisdiction that diagnosed the case.

DO NOT COUNT

- Cases in transient TB patients should not be counted when there is evidence that they have already been counted by another locality.

Federal Facilities (e.g., Military and Veterans Administration Facilities)

COUNT

- Cases in military personnel, dependents, or veterans should be counted by the jurisdiction of usual residence in the U.S. at the time of diagnosis. However, if the patient is diagnosed in a military facility outside the U.S but is treated within the U.S., the case should be counted by the jurisdiction where treatment was initiated.

DO NOT COUNT

- Do not count if the case was already counted by another locality in the United States.

Indian Health Service

COUNT

- Cases of TB within the Indian Health Service should be counted by the jurisdiction of usual residence at the time of diagnosis.
- However, for a specific group such as the Navajo Nation, which is geographically located in multiple states, health departments should discuss each case and determine which locality should count the case.

DO NOT COUNT

- Do not count if the case was already counted by another locality.

Correctional Facilities (e.g., Local, State, Federal, and Military)

COUNT

- Cases diagnosed in state, federal or military correctional facilities are considered residents of that facility and should be counted by the jurisdiction of the correctional facility where the patient was residing at the time of diagnosis.
- Cases diagnosed in local jails are not considered residents of that facility and therefore should be counted by the jurisdiction of their usual residence at the time of diagnosis.

DO NOT COUNT

- Do not count correctional facility residents' TB cases that were counted elsewhere by another locality or correctional facility, even if treatment continues at another locale or correctional facility.

Peace Corps, Missionaries, and Other Citizens Residing Outside the United States

DO NOT COUNT

- TB in persons diagnosed outside the United States should not be counted. TB in these persons should be counted by the country in which they are residing regardless of their plans to return to the United States for further work-up or treatment.

Suggested Administrative Practices

To promote uniformity in TB case counting, the following administrative procedures are recommended:

All TB cases verified during the calendar year by the 52 reporting areas with count authority (50 states, District of Columbia, and New York City) by December 31 will be included in the annual U.S. incidence count for that year. All tuberculosis cases verified during the calendar year by a reporting area with count authority from one of the remaining 7 reporting areas (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, Republic of Palau, and the U.S. Virgin Islands) are also counted but are not included in the annual incidence for the United States.

Cases for which bacteriologic results are pending or for which confirmation of disease is questionable for any other reason should not be counted until their status is clearly determined; they should be counted at the time they meet the criteria for counting. This means that a case reported in one calendar year could be included in the morbidity count for the following year. The reporting area with count authority should ensure that there is agreement between final local and state TB figures reported to CDC.

Currently, some reporting areas may not use this suggested protocol. Some of these areas may wait until the beginning of the following year when they have received and processed all of the TB cases for inclusion in the annual case count for the previous year. If reporting areas decide to revise their protocols, they should be aware that TB trends may change.

TB is occasionally reported to health departments over the telephone, by letter or fax, or on forms other than the Report of Verified Case of Tuberculosis (RVCT). In California, it is not acceptable to count a case of TB based on information received over the phone. Such information should be used as an indicator of a possible TB case (suspect) which should be investigated promptly for confirmation. All lab reports which are being used to confirm a case of TB should be verified by the case manager. Lab reports should be faxed and/or sent to the case manager for verification.

RVCT Form Completion Instructions

RVCT Report - Form Completion Instructions

This topic provides important instructions and information that you will need to fill out the RVCT Report forms, whether you enter them online, submit them via a data-exchange protocol, or fax them to the CDHS, TBCB Registry. Please read this entire topic before you fill out a report for the first time.

Topic contents:

Additional RVCT Instructions:

About the RVCT Report

The Report of Verified Case of Tuberculosis (RVCT) Report is a set of forms used in the U.S. by the Centers for Disease Control and Prevention (CDC) to collect information on cases of tuberculosis (TB). To report a verified case of tuberculosis, you must fill out and submit the RVCT report to the California Department of Health Services, Tuberculosis Control Branch (CDHS-TBCB) Registry.

Poppy icon indicates California specific information: When the "Poppy" icon appears before text in these instructions, it indicates that the information is specific to California. As of January 2001, California has incorporated a slightly modified RVCT form (DHS 8620 a, b, and c) to reflect a few changes specific to the reporting of TB in California.

In addition to the **RVCT** form, you must also fill out and submit the Follow Up 1 form (**Initial Drug Susceptibility** Report), and the Follow Up 2 form (**Case Completion** Report), as appropriate. All three forms have the same State Case ID number. The following three data collection forms comprise the entire RVCT report:

- **RVCT = Report of Verified Case of Tuberculosis**: Contains Questions 1 through 32 and user comments. Patient demographics, laboratory and risk behavior data are collected on this form. Complete this form for all patients.
- **Follow Up 1 = Initial Drug Susceptibility Report**: Contains Questions 33, 34 and user comments. Susceptibility results are collected on this form. Complete this form for all patients who had a culture that was positive for Mycobacterium tuberculosis (M. tuberculosis) complex.
- **Follow Up 2 = Case Completion Report**: Contains Questions 35 through 41 and user comments. Treatment outcomes are collected on this form.

Instructions and information for filling out the forms:

Fill out all questions: All questions on the forms should be completed according to the instructions in this topic and in the topics for specific Question fields.

Leave questions blank if information is pending: A question should be left blank if the information requested is pending.

Medical documentation is required: Patient history without medical documentation should not be accepted for clinical, treatment, and laboratory information requested on the RVCT forms. Date information can be obtained from documented medical records, such as those found in hospitals, clinics, directly observed therapy records, pharmacy and prescription records.

Important note about paper-based forms: You should never send paper-based completed RVCT forms to the CDC. Paper forms that you fill out at your LHJ should be stored in a secure (locked) location designated by each local health jurisdiction. Refer to the Confidentiality and Data Security sections below for additional information on protecting patient confidentiality. Also see Privacy Policy in this document for information about TB Registry privacy policies.

If you need paper forms, you can download them from this help system, see Downloading and printing RVCT Reports.

Case Definition

A verified case of TB is a case that is laboratory confirmed or, in the absence of laboratory confirmation, a case that meets the clinical case definition.

A clinically verified case of TB is a case that meets all of the following criteria:

- **A positive tuberculin skin test**; (Because HIV-infected persons frequently have false-negative tuberculin skin test results, the criterion of positive tuberculin skin test is not required as part of the clinical case definition in these individuals.)

and

- **Other signs and symptoms compatible with TB**: such as an abnormal, unstable (worsening or improving) chest x-ray, or clinical evidence of current disease;

and

- Treatment with two or more antituberculosis medications;

and

- Completed diagnostic evaluation.

The laboratory criteria for the diagnosis of TB are as follows:

- **Isolation of M. tuberculosis from a clinical specimen**; (Use of rapid identification techniques for M. tuberculosis (e.g., DNA probes and mycolic acids high-pressure liquid chromatography performed on a culture from a clinical specimen) are acceptable under this criterion.)

or

- **Demonstration of M. tuberculosis from a clinical specimen by nucleic acid amplification test**; (Current FDA-approved NAA tests are only approved for use on smear-positive respiratory specimens from patients who have received no antituberculosis therapy, less than 7 days of such therapy, or have not received such therapy in the last 12 months. However, because these instructions may change with modifications to the NAA tests, package inserts should be referred to with each use.)

or

- Demonstration of acid-fast bacilli in clinical specimen when a culture has not been or cannot be obtained.

Note: The three mycobacterial species of Mycobacterium tuberculosis complex (M. tuberculosis complex) are M. tuberculosis, M. bovis, and M. africanum. Disease caused by any of the three organisms should be reported as TB.

Case Counting

Note: Also see **Recommendations for Counting Reported Tuberculosis Cases**.

A case must not be counted more than once within any consecutive 12-month period. A case in which the patient had verified disease in the past should be counted again if the patient was discharged from supervision (e.g., completed therapy) or lost to follow-up for more than 12 months and disease can be verified again. A patient should not be counted a second time if 12 months have not passed since the patient was discharged from supervision.

Consider the following example:

A case of TB was reported to the health department in February, 1993, and began therapy on February 1, 1993. The health department verified and counted the case in March, 1993, and the patient completed therapy and was closed to supervision on July 27, 1993. The patient returned to the clinic in April, 1994, and was diagnosed with TB again. This new episode should not be reported or counted as a new case of TB because the previous episode was closed to supervision less than 12 months prior.

Surveillance data from this patient's episode of TB should be updated. Specifically, data collected on the Case Completion Report (Follow Up 2 Report) should be modified to reflect that the patient has been returned to follow-up and therapy. The previously reported Date Therapy Stopped (July 27, 1993, in this example) will need to be changed when the patient is again closed to supervision. In addition, other Case Completion Report information may need to be updated.

Patient Movement

See the **Transfer Protocols for TB Patients who Move** topic for complete instructions and information for reporting patients who move during TB treatment. The topic covers patient movement between LHJs within California, moving to another state in the United States, moving to Mexico, and moving internationally. The table of **Forms and Protocols for Interjurisdictional Transfer of TB Patients** in the Patient Movement topic lists the reporting forms and protocols required for each type of patient transfer.

Confidentiality

Because of the sensitive nature of some of the data collected, CDC has obtained an assurance of confidentiality for the expanded surveillance system. Information on the RVCT forms and in the TB surveillance software databases that would permit identification of any individual will be held in confidence and not released without the consent of the individual in accordance with Sections 306 and 308(d) of the Public Health Services Act (42 U.S.C. 242k and 242m(d)). Local patient identifier information, although collected by state and local health departments, will not be reported to CDC. Surveillance information reported to CDC will be used for statistical and analytic summaries in which no individual can be identified, and for special investigations of the natural history and epidemiology of TB.

Information: See **RVCT Report - Form Completion Instructions - HIV and AIDS** for special confidentiality instructions regarding HIV/AIDS patients.

Data Security

Note: Data security is the responsibility of the state or local health department.

Access to the RVCT forms and the TB surveillance software is restricted only to individuals authorized to perform TB surveillance activities. Completed paper forms should be stored in a secured (locked) area. Access to TB surveillance software is controlled through the use of a local user identifier (User ID) and password (your individual password should never be shared with another user). All other electronic surveillance files should also be protected with passwords known only to designated surveillance staff.

Record Management

It may be necessary to update existing RVCT forms if a case is re-opened (e.g., a patient lost to follow up is found, or a patient restarts treatment within 12 months of previous treatment for TB).

Follow Up Report-1: Initial Drug Susceptibility

The **Initial Drug Susceptibility Report** (**Follow Up 1 Report**) is part of the RVCT report (along with the RVCT form and the Follow Up 2 form). It contains Questions 33, 34 and a space for user Comments.

Complete and submit this report within 2 months after the initial RVCT was submitted, or when drug susceptibility results are available, whichever is later.

Susceptibility results are collected on this form. You must complete this form for all patients who had a culture that was positive for Mycobacterium tuberculosis (M. tuberculosis) complex. This form should be completed for culture-positive cases only (do not fill out a form for culture-negative cases).

Questions on the Follow Up 1 form are:

Q 33 Initial Drug Susceptibility Results, fu 1

Q 34 Susceptibility Results, fu 1

Information: For detailed information about entering data in the Follow Up 1 form, see topics for individual questions and the **RVCT Report - Form Completion Instructions** topic.

Follow Up Report-2: Case Completion

The **Case Completion Report** (**Follow Up 2 Report**) is part of the RVCT report (along with the RVCT form and the Follow Up 1 form). It contains Questions 35 through 41 and a space for user comments. Treatment outcomes are collected on this form.

Enter data into this report as information becomes available during patient follow up. This report should be completed when the case is closed to supervision.

 **California State**: This form should be completed when a patient completes treatment, moves out of your jurisdiction, dies, is lost, is uncooperative or refuses treatment, or is found not to have TB.

If a patient moves: Please see **RVCT Follow-Up 2 Reporting For Tuberculosis Patients that Move** for specific instructions.

Questions on the Follow Up 2 form are:

Q 35 Sputum Culture Conversion Documented, fu 2

Q 36 Date Therapy Stopped, fu 2

Q 37 Reason Therapy Stopped, fu 2

Q 38 Type of Health Care Provider, fu 2

Q 39 Directly Observed Therapy, fu 2

Q 40 Final Drug Susceptibility Results, fu 2

Q 41 Final Susceptibility Results, fu 2

 **Information:** For detailed information about entering data in the Follow Up 2 form, see topics for individual questions and the **RVCT Report - Form Completion Instructions** topic.

00 - 32 - RVCT Questions (data fields)

Q 00 Patient Information, rvct

"Patient Information" provides personal information that helps to specifically identify the patient.

Entry fields in Q 00 Patient Information

You must enter data in all required fields. The RVCT form will not be accepted if required fields are blank.

Field	Description	Entry guidelines
Last Name (required)	Patient's full name, including first, last, and middle initial (if any). You must enter data in the Last Name and First Name fields.	Enter the patient's Last Name, First Name, and Middle Initial (if no middle initial, leave the field blank). Enter alphanumeric characters only and do not put spaces before or after the name.
First Name (required)		
Middle Initial		
Address	Patient's current address at the time of diagnosis.	Enter the address that the patient states as his/her current place of residence. (Also see Q 04, Address for Case Counting.)
City		
State		
ZIP code		

Additional guidelines for entering patient information:

Note: Patient history without medical documentation should not be accepted for clinical, treatment, and laboratory information requested on the RVCT forms. Date information can be obtained from documented medical records, such as those found in hospitals, clinics, directly observed therapy records, pharmacy and prescription records.

Warning: When you are creating a State or Local Case number for Q 02, remember that you must not include personal identifiers. Do not use names, initials, social security numbers, addresses, phone numbers, date of birth, or other information that could potentially identify a patient.

Q 01 State Reporting, rvct

"State Reporting" indicates the name and two-letter abbreviation of the area reporting this case.

Entry fields in Q 01 State Reporting

Field	Description	Entry guidelines
Specify	Name of state (area) reporting the case	The TB surveillance software automatically pre-fills this field with "California." You cannot edit this field.
Alpha state code	Two-letter abbreviation of the reporting state.	The TB surveillance software automatically pre-fills this field with "CA." You cannot edit this field.

Additional guidelines for entering State reporting information

This question is pre-filled by the TB surveillance software, you do not need to edit or enter information for this question.

Q 02 Case Numbers for State and City/County, rvct

The case numbers for State and City/County (local case number) identify a case as completely unique. For example, if two patients have the same name, the case numbers will identify the RVCT Reports for these patients as individual cases despite the name duplication (other information, such as sex and race, also helps to distinguish individual cases).

An individual patient may have more than one RVCT Record, each with a separate case number. For example, this may occur when therapy stops, the case is closed, and then the patient relapses. The second occurance of TB is treated as a new case with a different case number.

Entry fields in Q 02 Case Numbers for State and City/County

You must enter data in all required fields. The RVCT form will not be accepted if required fields are blank.

Field	Description	Entry guidelines
State case number (required)	The official state identification number for the case. You must assign and enter a State case number in this field.	You can enter a maximum of 9 characters, in the character positions as follows: **1=count year; 2,3=LHJ code; 4,5,=LHJ discretion; 6,7,8,9=sequence number**. For example: **560EM0010** (The 10th case reported from Alameda County in 2005. The designation in positions 4-5 is for the county's discretionary use. In the example it indicates the city of Emeryville—this designation could be alpha or numeric.) The number must be unique within the Month-Year Reported (Q 05). (Case numbers cannot be repeated during a calendar year.) See Assigning case numbers below, for more information.
City/county case number	The official City/County case number for the case. (This number is sometimes referred to as the "Local case number.")	You can enter a maximum of 9 alphanumeric characters The number must be unique within the Month-Year Reported (Q 05). (Case numbers cannot be repeated during a calendar year.) See Assigning case numbers below, for more information. **Note:** This is not a required field, however the TB Registry does recommend that you use and enter a City/county case number. This will help with patient/case identification and use of the Search feature in CWTB.

Additional guidelines for entering Case Numbers

Warning: PROTECT PATIENT CONFIDENTIALITY: Case numbers must not include personal identifiers. In order to maintain patient confidentiality, do not use names (neither patient nor provider), initials, social security numbers, addresses, phone numbers, or other information that could potentially identify a patient. Case numbers are transferred to CDC, and cannot personal identifying information.

California specific for suspect cases: A record of a *suspect* case of tuberculosis should be maintained locally at your LHJ. Do not give a suspect case a state case number or submit the case to the TB Registry until the case is a verified case of tuberculosis that is laboratory confirmed or, in the absence of laboratory confirmation, a case that meets the clinical case definition.

Assigning case numbers:

- **Every case must have a case number**: Every case reported, whether from a city/county or state surveillance system, must have a unique case number for identification purposes.

The state case number is the official state identification number for the case. If additional communication is required about a record between CDC and the state, this number is used to identify the record.

Note: The city/county case number is optional, but should be entered if it is used by the county.

- **Case numbers cannot be repeated during a calendar year (January 1 through December 31)**: Once a case number has been assigned, submitted, and transferred to the next level, it cannot be changed or reused, even after a case has been deleted.
- **One case per year, per case number**: State and City/County case numbers may not be assigned to more than one case during a calendar year.
- **An individual case may have identical State and City/County numbers**: A single case may be assigned identical city/county and state case numbers for the calendar year.
- State case numbers must be assigned using the required scheme: The format for the State Case Number is:
  - *9 characters*: (2 characters may be alpha or numeric, 7 must be numeric) as follows:
  - *Character position 1*: **one-digit numeric year code** in character position 1 (the "count" year).
  - *Character positions 2 and 3*: **two-digit numeric county code** for the facility reporting the case (see LHJ codes).
  - *Character positions 4 and 5*: **two-character alpha or numeric code** at the LHJs discretion (LHJ may use these characters for their own identification purposes).
  - *Character positions 6, 7, 8, and 9*: **four-digit case sequence number** (must be unique to the case, e.g., 0001 for the first case reported in the year, 0002 for the second case, etc.).

Acceptable case numbers:

560EM0001, 560EM0002 The first and second cases (0001, 0002) reported from Alameda County in 2005 (in this example the LHJ uses an alpha designation "EM" for the city of Emeryville in character positions 4 and 5).

541000012 The 12th case reported from San Mateo county in 2005 (in this example the LHJ does not use character positions 4 and 5 for a custom designation).

Unacceptable case numbers:

MCCRAYEUG Client name used for case number.
049226142 Social Security Number used as case number.

Q 03 Date Submitted, rvct

The "Date Submitted" questions indicates the date that the RVCT form (Questions 1 - 32) was submitted to or completed by your Local Health Jurisdiction. It also shows the name of the person who should be contacted if there is a question about data on the form.

Entry fields in Q 03 Date Submitted

Field	Description	Entry guidelines
Month Day Year	This is the date that RVCT form was completed at your Local Health Jurisdiction.	Enter the full date in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**. If you are entering the form online (you are not working from a paper-based form), you may use the current date. If you are transmitting the report by data exchange, "Date Submitted" will be the date the report was accepted (successfully transmitted).
By	Name of the person to contact with questions about the information on the form.	Enter the both the first and last name.

Additional guidelines for entering Date Submitted information

- If you are entering the information online, use the date on your paper form, or use the current date if you are entering information for the first time.
- If you are submitting the form by data exchange, the date will most likely be the date that you entered the RVCT information into your patient management system.

Q 04 Address for Case Counting, rvct

The "Address for Case Counting" indicates the city, county, and zip code of the patient's residence. It also indicates if the patient lives within the city limits. To the extent possible, the address for case counting should represent the home address (whether permanent or temporary) of the patient.

The guidelines in this topic apply to your specific reporting area.

Entry fields in Q 04 Address for Case Counting

Field	Description	Entry guidelines
City	The City that the patient currently states as their "home" city.	Enter a valid city for your reporting area.
Within city limits Yes / No	Indicates if the patient resides within the limits of the city entered in the City field.	Select **Yes** or **No** to indicate if the patient lives with the city limits of the city entered in the City field.
County	The County in which the City is located. For example, the city of Berkeley is within Alameda County.	Enter a valid county for your reporting area. Note that the city in the City field must be within the County you specify.
ZIP code	The ZIP code for the Patient's street address within the specified City.	Enter the appropriate 5-digit ZIP code for the patient's street address within the City specified. If you know it, also enter the 4-digit extended ZIP code.

Additional guidelines for entering Address for Case Counting information

California State guidelines: Guidelines for counting and reporting tuberculosis cases in California differ slightly from the CDC national guidelines. California specific guidelines can be found in *Recommendations for Counting Reported Tuberculosis Cases-California Edition* (February 1998) (*Section 1* of the *Tuberculosis Registry Guidelines*). In this document, see **Recommendations for Counting Reported Tuberculosis Cases**.

Patient resides in diagnosing community

- If a person is diagnosed in the community which they consider their home, he or she should be included in the morbidity count for that area, and the city, county, and zip code of residence should be entered.

Patient is from a community other than the diagnosing community

- If a newly diagnosed patient is an out-of-area resident who will return to his or her home for treatment, they should be included in the morbidity count of their home area, and the city, county, and zip code of their home area should be entered. For example, a patient in a community only for hospitalization and diagnosis is not considered a case in that community, but rather in the area in which he or she resides. Communication between health departments may be necessary to decide which jurisdiction will count the case.

Patient is an immigrant, migrant, US Military, foreign visitor, or other transient status

- Immigrants (i.e., resident aliens living in the United States), migrants, United States military personnel, and other transient individuals should be counted in the community in which they

reside at the time of diagnosis. The city, county, and zip code of residence at the time of diagnosis should be entered.

- If a foreign visitor is diagnosed with TB in the United States, is receiving antituberculosis drug therapy, and is to remain in the country for at least 90 days, the case should be counted in the area of current residence, and the city, county, and zip code of his or her current residence should be entered. (Also see Q 11 and Q 12.)


For California specific protocol regarding foreign visitors, see **Recommendations for Counting Reported Tuberculosis Cases (Immigrants, Refugees, Aliens, Border Crossers, and Foreign Visitors**).

- Persons arriving in the United States who were diagnosed with TB before arriving here should not be counted as a case of TB in the United States. Such cases are considered to have occurred in another country, even if therapy is continued or completed in the United States.

Patient is a resident of a long-term care or correctional facility

- **Long-term care facility**: Patients who are residents of long term care facilities at the time of diagnosis should be counted in the area in which the facility is located, and the city, county and zip code of the facility should be entered in this field. (Also see Q 24, Q 25, and Q 26.)
- Correctional facility (local, state, federal, and military): For California specific protocol regarding residents of a correctional facility, see **Recommendations for Counting Reported Tuberculosis Cases (Correctional Facilities)**.

Patient is homeless or without fixed residence

- Homeless persons or others without any fixed residence should be counted in the community in which they are living at the time of diagnosis (e.g., the locality of the shelter in which the patient was living). Enter the city, county and zip code of that locality. (Also see Q 24.)

Transfer Cases

- Fifty-nine reporting areas are responsible for reporting cases of TB to CDC. These reporting areas are: the 50 states, the District of Columbia, New York City, Puerto Rico, Guam, the Republic of Palau, the U.S. Virgin Islands, the Federated States of Micronesia, Northern Marianna Islands, and American Samoa. Because of the additional follow-up reporting requirements for expanded surveillance, specific instructions are necessary for the submission of forms for patients who move within a reporting area, and for those who move from one reporting area to another during the course of treatment.
- To minimize the number of TB patients who are lost to follow-up, street address information should be updated regularly during the course of treatment.
- In addition, patients should be asked periodically if they anticipate moving, so that necessary arrangements can be made to maintain continuity of care and ensure submission of follow up reports for the RVCT. Patients who anticipate moving should be encouraged to report their new address, so that necessary patient information can be forwarded to health care providers and to the TB control program in the area to which the patient is moving.
- Communication between TB control programs to ensure continuity of care and submission of follow-up reports regarding a patient who is moving from one area to another should be conducted in the most efficient manner possible.

Patients who move within California

- 
California State: California guidelines for patients who move from one reporting area in California to another area in California differ slightly from the CDC national guidelines. Please see **RVCT Report - Form Completion Instructions - Patient Movement** for California specific instructions.

Patients who move to other States

- If a TB patient for whom an RVCT record exists moves from one reporting area to another (e.g., from state A to state B, or from Washington, DC to New York City, etc.), the responsibility for submitting follow up reports to CDC remains with the state that initially reported the case to CDC and counted it (e.g., state A). This responsibility remains with the initial area for surveillance purposes only, in order to minimize duplication of case reports and to simplify the reporting of the final disposition of the case. In other words, State B will be managing and following the

patient, and will need to share follow up surveillance information with State A, which will officially submit follow up information to CDC using TIMS.

- To facilitate in this process, state A should inform state B that the case has been reported to CDC and counted. State A should also inform state B of the surveillance information that has been reported to CDC, and the information that will need to be collected by state B and forwarded to state A for reporting to CDC.
- Surveillance information requested on the follow up reports to the RVCT can be exchanged by telephone, or through the mail, following CDC's Recommended Guidelines for Maintaining Confidentiality of the TB Surveillance System (see Confidentiality and Data Security), and all laws applicable in the state and local jurisdictions involved.

Q 05 Date Reported, rvct

"Date Reported" is the date that a health department (county or state) first became aware that the patient might have TB.

Entry fields in Q 05 Date Reported

You must enter data in all required fields. The RVCT form will not be accepted if required fields are blank.

Field	Description	Entry guidelines
Month **Day** **Year** (required)	This is the date that you first became aware that the patient might have TB. Applies only to the current episode of TB if the patient has had prior episodes. You must enter data in all fields.	Enter the full date in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**.

Additional guidelines for entering Date Reported information

If the patient has had a previous diagnosis of tuberculosis (Q 14), Date Reported applies to the current episode.

Q 06 Date Counted, rvct

The month-year counted is the month and year that the health department responsible for counting TB cases (usually the state health department) verified the case as TB and included it in the official case count.

Information: See **Recommendations for Counting Reported Tuberculosis Cases** for detailed information and recommendations.

Entry fields in Q 06 Date Counted

Field	Description	Entry guidelines
Month **Day** **Year**	The date that the case should be counted as a verified case of TB	Enter the date that your local health department verified the case as TB. This is the date that will be included in the official case count for the CDC. Note: If you are entering the form online, you may be asked to enter the Count Date when you complete the form. If this is the case, Q 6 on the RVCT form will be automatically filled by the surveillance software. If the form has been transmitted by Data Exchange, the Count Date is included in the Report.

Additional guidelines for entering Date Counted information

Cases for which bacteriologic results are pending or for which verification of disease is questioned for any other reason should be counted only after they are determined to be verified cases. This could mean that a case that was reported in one year may not be counted until the following year.

For example, if a patient is reported to the health department in December 1993, but bacteriologic or clinical evidence of TB is not available until January 1994, the case should be counted in January 1994 (when TB was verified), not in 1993.

Q 07 Date of Birth, rvct

The "Date of Birth" indicates the month, day, and year when the patient was born.

Entry fields in Q 08 Date of Birth

You must enter data in all required fields. The RVCT form will not be accepted if required fields are blank.

Field	Description	Entry guidelines
Month Day Year (required)	Indicates the month, day, and year of birth for the patient. For example: 04/26/1968. You must enter a date, if you do not know the entire date, enter 99/99/9999	Must be in valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**. **A complete date of birth is required**. Partial dates are not acceptable. If the month, day, and year of birth are not all known, enter **99/99/9999** in the field.

Additional guidelines for entering Date of Birth information

 The date of birth is another piece of confidential information about the patient and should be treated as such.

Q 08 Sex, rvct

Indicates the gender of the patient, male, female, or unknown.

Topic contents:

Entry fields in Q 08 Sex

Field	Description	Entry guidelines
Male	Gender of the patient is male.	Select **Male** or **Female** for the biological gender of the patient. If you do not know the gender, select "**Unknown**." **The sex chosen must correspond to the anatomic values listed in**: Major Site of Disease (Q 15), Additional Site of Disease (Q 16), Microscopic Exam of Tissue and Other Body Fluids (Q 19), and Culture of Tissue and Other Body Fluids (Q 20). See Appendix A .
Female	Gender of the patient is female.	
Unknown	Gender of the patient is unknown.	

Additional guidelines for entering Sex information

Note: The gender (sex) is another piece of confidential information about the patient and should be treated as such.

Information: The sex you select must match the anatomic codes you choose in Q 15, Q 16, Q 19, and Q 20. For example, if the sex is male you would not choose anatomic code "78 Ovary."

Q 09 Race, rvct

The answer to this question should be based on the individual's self identity or self reporting. Patients shall be offered the option of selecting one or more racial designations.

Entry fields in Q 09 Race

You may select one or more of the Race fields in this question.

Field	Description	Entry guidelines
American Indian or Alaskan Native	A person who has origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.	Select **American Indian or Alaskan Native** if appropriate.
Asian (***specify***)	A person who has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	Select **Asian** if appropriate. **Specify**: Enter or select the Asian Specify code from the drop-down list.
Black or African American	A person who has origins in any of the black racial groups of Africa	Select **Black or African American** if appropriate.
Native Hawaiian or Pacific Islander (**specify**)	A person who has origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	Select **Native Hawaiian or Pacific Islander** if appropriate. **Specify**: Select the Native Hawaiian or Other Pacific Islander Specify code from the drop-down list.
White	A person who has origins in any of the original peoples of Europe, the Middle East, or North Africa.	Select **White** if appropriate.
Unknown	The race of the patient is unknown.	Select **Unknown** if appropriate.

Additional guidelines for entering Race information

The race is another piece of confidential information about the patient and should be treated as such.

Q 10 Ethnicity, rvct

The answer to this question should be based on the individual's self identity or self reporting.

Entry fields in Q 10 Ethnicity

Field	Description	Entry guidelines
Hispanic or Latino	A person who considers themselves to be of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish origin or culture, regardless of race.	Select **Hispanic or Latino** if appropriate.
Not Hispanic or Latino	The person does not consider themselves to be Hispanic or Latino (regardless of race, culture, or country of origin).	Select **Not Hispanic or Latino** if appropriate.
Unknown	The ethnicity of the person is unknown	Select **Unknown** if the ethnicity of the person is unknown.

Additional guidelines for entering Ethnicity information

Note: The ethnicity is another piece of confidential information about the patient and should be treated as such.

Q 11 Country of Origin, rvct

"Country of origin" is the country in which the patient lived and probably held citizenship during the early years of life. It is closely associated with Q 12 Month/Year Arrived in U.S.. You must correlate your entry in this question with the data you've entered in Month/Year Arrived in U.S. (Q 12). Please see Guidelines in this topic for entry instructions for U.S. territories that report TB cases to CDC (i.e., American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands).

Entry fields in Q 11

Field	Description	Entry guidelines
U.S.	A person who was born in the United States or born overseas to U.S. parents (e.g., born on a military installation).	Select **U.S.** if appropriate. (See Guidelines in this topic for date-entry instructions for U.S. territories that report TB cases to CDC.)
Not U.S. ***(specify country)***	The country of origin is not the United States	Select **Not U.S**. if the country of origin is not the United States. **Specify**: Enter the appropriate two-letter abbreviation selected from the **Country Code List**. For this question, outlying U.S. areas (e.g., Puerto Rico, Guam, Virgin Islands) are not considered part of the United States; they should be listed as separate countries and their codes entered in the **Not U.S. Specify** field.
Unknown	The country of origin is not known.	Select **Unknown** if you do not know the country of origin.

Additional guidelines for entering Country of Origin information

Entry instructions for U.S. territories that report TB cases to CDC

Examples of territories that report TB cases to CDC are: American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands).

- If the Country of Origin is one of the 50 states of the United States, or if the client were born overseas to U.S. parents (e.g., born on a military installation):

  Select the **U.S.** field.

  Leave the field for **Not U.S** blank.

- If the Country of Origin is one of the territories listed above and is the same territory that is reporting the case (e.g., the country of origin is Puerto Rico and Puerto Rico is reporting the case):

  Leave the **U.S.** field blank.

  Enter the two-letter code for the territory in the **Not U.S. Specify** field.

- If the Country of Origin is one of the territories listed above, but is not the same territory that is reporting the case (e.g., the country of origin is Federated States of Micronesia, but Guam is reporting the case):

  Leave the field for **Not U.S** blank.

Enter the two-letter code for the territory of origin (e.g., Federated States of Micronesia in this example in the **Not U.S. Specify** field.

- If the Country of Origin is not the United States, and is not one of the territories listed above (e.g., the country of origin is the Philippines, and Guam is reporting the case).

  Leave the **U.S.** field blank.

  Enter the two-letter code for the country of origin (e.g., Philippines in this example in the **Not U.S. Specify** field.

Q 12 Month/Year Arrived in U.S., rvct

This question indicates the date that a non-U.S. born person arrived in the United States. It is closely associated with Q 11 Country of Origin. You must correlate your entry in this question with the data you've entered in Country of Origin (Q 11). Please see Guidelines in this topic for entry instructions for U.S. territories that report TB cases to CDC (i.e., American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands).

Entry fields in Q 12 Month/Year Arrived in U.S.

Field	Description	Entry guidelines
Month / Year	The month and year that a person who was not born in the United States arrived in the U.S. (See Guidelines in this topic for data-entry instructions for U.S. territories that report TB cases to CDC.)	If **U.S.** is selected in Q 11 Country of Origin do not enter a date (leave the field blank). Must be in valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**. **A partial date is acceptable**: If only the year of arrival is known, enter 99 for the month and the 4-digit year. For example, if the patient arrived in 1963, but the month cannot be determined, enter "99 1963". If both the month and year of arrival are not known, enter "99 9999".

Additional guidelines for entering Month/Year Arrived in U.S. information

Entry instructions for U.S. territories that report TB cases to CDC

Note: Examples of territories that report TB cases to CDC are: American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands).

- If the Country of Origin is one of the 50 states of the United States, or if the client were born overseas to U.S. parents (e.g., born on a military installation):

  Leave "Month-Year Arrived in U.S." blank.

- If the Country of Origin is one of the territories listed above and is the same territory that is reporting the case (e.g., the country of origin is Puerto Rico and Puerto Rico is reporting the case):

  Enter '99' for the month and '9999' for the year in "Month-Year Arrived in U.S."

- If the Country of Origin is one of the territories listed above, but is not the same territory that is reporting the case (e.g., the country of origin is Federated States of Micronesia, but Guam is reporting the case):

  Enter the month and year that the patient arrived in the territory that is reporting the case (e.g., Guam, in this example) in "Month-Year Arrived in U.S."

- If the Country of Origin is not the United States, and is not one of the territories listed above (e.g., the country of origin is the Philippines, and Guam is reporting the case):

  Enter the month and year that the patient arrived in the territory that is reporting the case (e.g., Guam, in this example) in "Month-Year Arrived in U.S.

Q 13 Status at Diagnosis of TB, rvct

"Status at Diagnosis of TB" indicates whether the patient was alive or dead at the time of diagnosis.

Entry fields in Q 13 Status at Diagnosis of TB

Field	Description	Entry guidelines
Alive	The patient was alive at the time of diagnosis of TB.	Select **Alive** if the patient was alive at the time of diagnosis (see Guidelines, below).
Dead	The patient was dead at the time of diagnosis of TB.	Select **Dead** if the patient was deceased at the time the investigation of possible TB was initiated (see Guidelines, below).
Unknown	The status of the patient is unknown.	Select **Unknown** if the status of the patient is not known.

Additional guidelines for entering Status at Diagnosis of TB information

Status Classifications

Alive: Patients whose TB was suspected and who were started on at least two antituberculosis drugs prior to the day of death are classified as alive at the time of diagnosis even though the case may not be verified and counted until after death.

Dead: Patients who were only on one antituberculosis drug prior to the day of death because TB disease was not suspected, and who were then diagnosed with TB after death are classified as dead at the time of diagnosis. For example, if a person who was taking Isoniazid as preventive therapy for TB infection dies, and is found after death to have had TB disease, this person should be classified as dead at diagnosis.

Q 14 Previous Diagnosis of Tuberculosis, rvct

Indicates whether or not the patient has been previously diagnosed one or more times with Tuberculosis.

Entry fields in Q 14 Previous Diagnosis of Tuberculosis

Field	Description	Entry guidelines
Yes **No** **Unknown**	Indicates whether or not the patient has been previously diagnosed with Tuberculosis.	Select **Yes** if the patient has had a previous diagnosis of TB. If you select Yes, you must also provide the year of previous diagnosis. (See Guidelines, below.) Select **No** if the patient has not been previously diagnosed with TB. Select **Unknown** if appropriate.
If yes, list year of previous diagnosis	The year in which the patient was previously diagnosed with TB. (If more than one diagnosis, this should be the most recent previously diagnosed episode of TB.)	If yes, provide the year in which the patient's previous episode of disease was diagnosed. (If the patient has had more than one diagnosis of TB, enter the year of the most recent diagnosis.)
If more than one previous episode, check here	Indicates that the patient has had more than one previous diagnosis of TB prior to the current episode.	Select this field if the patient has had more than one previous diagnosis of TB. Enter the most recent previous diagnosis date in the Year field.

Additional guidelines for entering 14 Previous Diagnosis of Tuberculosis information

A patient is considered to have had a previous diagnosis of TB if they had verified disease in the past, had been discharged (e.g., completed therapy) or lost to supervision for more than 12 consecutive months, and has verified disease again.

If the patient has been previously diagnosed, provide the year in which the patient's previous episode of disease was diagnosed. For example, if the patient was diagnosed in 1985, was discharged or lost to supervision in 1986, and is found to have verified disease again in 1994, enter the number "1985" in the boxes provided. If the patient had more than one previous episode, enter the year of the most recent previous episode, and select the "If more than one previous episode, check here" box.

Q 15 Major Site of Disease, rvct

Indicates the major site of TB disease (including "site not stated" if the site is unknown). Note that you must also enter an Anatomic code if you select "Other" as a major site of disease. You can select only one major site of disease on Q 15, however, you may select multiple additional sites of disease on Q 16 "Additional Site of Disease."

Entry fields in Q 15 Major Site of Disease

Field	Description	Entry guidelines
Major Site of Disease	**Major Site of Disease Categories 00 through 90** 00 Pulmonary 10 Pleural 20 Lymphatic: Cervical 22 Lymphatic: Intrathoracic 23 Lymphatic: Other 29 Lymphatic: Unknown 30 Bone and/or Joint 40 Genitourinary=Male 40 Genitourinary=Female 50 Miliary=Male 50 Miliary=Female 60 Meningeal 70 Peritoneal 80 Other=Male 80 Other=Female	Select only one major site of disease. If you select #80 "**Other**," you must also enter an Anatomic Code. If the site is unknown, select #90 "Site not stated." See guidelines, below for Lymphatic and California specific. **Note: Lymphatic**: Intrathoracic includes hilar, bronchial, mediastinal, peritracheal, and other lymph nodes within the thorax.
If site is "Other" enter Anatomic Code	(See Appendix A for anatomic code lists.)	If the major site is **Other**, select the appropriate anatomic code from the **Anatomic Code** drop-down list. **Warning:** The same anatomic codes cannot be entered for both Major Site of Disease and Additional Site of Disease (Q 16).

Additional guidelines for entering Major Site of Disease information

California State: Select **Pulmonary** as the major site of disease if the patient has any pulmonary disease.

- If the patient has both pulmonary disease and miliary disease, select **Pulmonary** as the major site of disease Q 15, and **Miliary** as the additional site of disease Q 16.
- California regards Pulmonary tuberculosis as the most important to highlight because of the increased likelihood of tuberculosis transmission from persons with pulmonary TB and the need for prompt contact investigations of persons with pulmonary TB.

Q 16 Additional Site of Disease, rvct

Indicates the additonal sites of TB disease (in addition to the major site specified in Q 15). Note that you must also enter an Anatomic code if you select "Other" as an additional site of disease.

Entry fields in Q 16 Additional Site of Disease

Field	Description	Entry guidelines
Additional Site of Disease	**Additional Site of Disease Categories 00 through 90** 00 Pulmonary 10 Pleural 20 Lymphatic: Cervical 22 Lymphatic: Intrathoracic 23 Lymphatic: Other 29 Lymphatic: Unknown 30 Bone and/or Joint 40 Genitourinary=Male 40 Genitourinary=Female 50 Miliary=Male 50 Miliary=Female 60 Meningeal 70 Peritoneal 80 Other=Male 80 Other=Female	If the patient's TB is known to affect additional sites, select all the appropriate sites. If you select #80 "**Other**," you must also enter an Anatomic Code. **Note:** If you select #50 "Miliary" you cannot select any other additional sites of disease.
If site is "Other" enter Anatomic Code	(See Appendix A for anatomic code lists.)	If an additional site is **Other**, select the appropriate anatomic code from the Anatomic Code drop-down list.
If more than one additional site, check here	Indicates that two or more additional sites of disease have been selected.	Select this field only if you have selected more than one additional site of disease. **Note:** If you have selected #50 "Miliary" you cannot select any other additional sites of disease.

Additional guidelines for entering Additional Site of Disease information

Warning: The same anatomic codes cannot be entered for both Additional Site of Disease and Major Site of Disease (Q 15).

Q 17 Sputum Smear, rvct

Indicates the results of a sputum smear examination. If the results of the smear are pending, do not submit the RVCT until you have received the results. **Sputum includes spontaneous and induced sputum. Do not include the results of microscopic examination of pulmonary secretions obtained by tracheal suction, bronchoscopy procedures (e.g., bronchial washing, scrapings, biopsies), or gastric aspiration (see Q 19 and Q 20).**

Entry fields in Q 17 Sputum Smear

Field	Description	Entry guidelines
Positive	The result of the sputum smear is positive.	If several examinations have been done, select **Positive** if any one is positive for acid-fast organisms.
Negative	The result of the sputum smear is negative.	Select negative if the results of all examinations (or the only examination) were negative.
Not done	The sputum smear has not been done.	Select **Not done** if a sputum smear is known not to have been done.
Unknown	The results of the sputum smear are not known, or you do not know if the smear has been done.	Select **Unknown** if it is not known if a sputum smear was performed, or if the results are not known for a reason other than pending results (e.g., result was lost or specimen contaminated, and no other specimens can be obtained).

Additional guidelines for entering Sputum Smear information

If you select **Positive**, the Major and/or Additional Site of Disease (Q 15, Q 16) must equal 00 (Pulmonary), 10 (Pleural), 22 (Lymphatic: Intrathoracic), or 50 (Miliary).

If the Major and/or Additional Site of Disease (Q 15, Q 16) is **Other**, the anatomic codes you enter for those questions must contain one of the following: 18 (Nose), 19 (Accessory Sinus) , 20 (Nasopharynx), 21 (Epiglottis and Larynx), and 22 (Trachea).

Q 18 Sputum Culture, rvct

Indicates the results of a sputum culture. If the results of the culture are pending, you may leave this question blank.

Entry fields in Q 18 Sputum Culture

Field	Description	Entry guidelines
Positive	The result of the sputum culture is positive for M. tuberculosis complex.	If several examinations have been done, select **Positive** if any one is positive for M. tuberculosis complex.
Negative	The result of the sputum culture is negative for M. tuberculosis complex.	Select **Negative** if the culture grows organisms other than M. tuberculosis, M. bovis or M. africanum, or if the results of all examinations (or the only examination) were negative for M. tuberculosis complex.
Not done	The sputum culture has not been done.	Select **Not done** if a sputum culture is known not to have been done.
Unknown	The results of the sputum smear are not known, or you do not know if the smear has been done.	Select **Unknown** if it is not known if a sputum culture was performed, or if the results are not known for a reason other than pending results (e.g., result was lost or specimen contaminated, and no other specimens can be obtained).

Additional guidelines for entering Sputum Culture information

Information: If you select **Positive**, the Major and/or Additional Site of Disease (Q 15, Q 16) must equal 00 (Pulmonary), 10 (Pleural), 22 (Lymphatic: Intrathoracic), or 50 (Miliary).

If the Major and/or Additional Site of Disease (Q 15, Q 16) is **Other**, the anatomic codes you enter must contain one of the following: 18 (Nose), 19 (Accessory Sinus) , 20 (Nasopharynx), 21 (Epiglottis and Larynx), and 22 (Trachea).

Q 19 Microscopic Exam of Tissue and Other Body Fluids, rvct

Indicates the results of the microscopic exam. If the results of the exam are pending, you may leave this question blank.

Entry fields in Q 19 Microscopic Exam of Tissue and Other Body Fluids

Field	Description	Entry guidelines
Positive	The result of the microscopic exam is positive for acid-fast organisms.	Select **Positive** if any tissue or fluid (e.g., tracheal aspirate, bronchoscopy procedures (e.g., bronchial washing, scrapings, or biopsies), gastric aspirate, pleural fluid, urine, bone marrow, cervical lymph node, etc.) other than sputum was positive for acid-fast organisms.
Negative	The result of the microscopic exam is negative for acid-fast organisms.	Select **Negative** if all microscopic exams were negative for acid-fast organisms.
Not done	The microscopic exam has not been done.	Select **Not done** if exams are known not to have been done.
Unknown	The results of the microscopic exam are not known, or you do not know if the exam has been done.	Select **Unknown** if it is not known if exams were performed or if the results are not known for a reason other than pending results (e.g. result was lost or specimen contaminated, and no other specimens can be obtained).
If positive, enter Anatomic Code(s)	(See Appendix A for anatomic code lists.)	If positive, select the appropriate code from the Anatomic Code list. Up to two tissue or fluid codes may be entered. (See note under Guidelines, below.)

Additional guidelines for entering Microscopic Exam of Tissue and Other Body Fluids information

Note: Acceptable anatomic codes are based on the values entered in Sex (Q 08), Major Site of Disease (Q 15), Additional Site of Disease (Q 16), and Culture of Tissue and Other Body Fluids (Q 20).

Q 20 Culture of Tissue and Other Body Fluids, rvct

Indicates the results of the tissue and body fluids (other than sputum) culture. If the results of the exam are pending, do not submit the RVCT until you have received the results.

Entry fields in Q 20 Culture of Tissue and Other Body Fluids

Field	Description	Entry guidelines
Positive	The result of a culture is positive for M. tuberculosis complex.	Select **Positive** if any tissue or fluid (e.g., tracheal aspirate, bronchial washing, gastric aspirate, pleural fluid, urine, bone marrow, cervical lymph node, etc.) culture other than sputum was positive for M. tuberculosis complex.
Negative	The result of a culture is negative for acid-fast organisms.	Select **Negative** if all cultures were negative for M. tuberculosis complex.
Not done	The culture has not been done.	Select **Not done** if cultures are known not to have been done.
Unknown	The results of the cultures are not known, or you do not know if the cultures have been done.	Select **Unknown** if it is not known if cultures were performed or if the results are not known for a reason other than pending results (e.g. result was lost or specimen contaminated, and no other specimens can be obtained).
If positive, enter Anatomic Code(s)	(See Appendix A for anatomic code lists.)	If positive, select the appropriate code from the Anatomic Code list. Up to two tissue or fluid codes may be entered. (See note under Guidelines, below.)

Additional guidelines for entering Culture of Tissue and Other Body Fluids information

Note: Acceptable anatomic codes are based on the values entered in Sex (Q 08), Major Site of Disease (Q 15), Additional Site of Disease (Q 16), and Culture of Tissue and Other Body Fluids (Q 20).

Q 21 Chest X-Ray, rvct

Indicates the result of the chest radiograph taken during the diagnostic evaluation.

Entry fields in Q 21 Chest X-Ray

Field	Description	Entry guidelines
Normal	Indicates whether or not the chest X-Ray shows abnormalities.	Select **Normal** if the chest X-Ray does not show any abnormalities.
Abnormal		Select **Abnormal** if the chest X-Ray shows abnormalities. If you select Abnormal, you must also indicate the disease conditions (see "If Abnormal" fields in this table).
Not done	Indicates that a chest X-Ray has not been done.	Select **Not done** if chest radiographs are known not to have been done.
Unknown	The chest X-Ray results are unknown, or you do not know if an X-Ray has been done.	Select **Unknown** if it is not know if chest radiographs were done, or if the results of chest radiographs are unknown.
If Abnormal (cavitary / noncavitary)	Indicates if the abnormal condition was one of the following: **Cavitary** Noncavitary consistent with TB **Noncavitary *not* consistent with TB**	If abnormal, indicate if any of the chest radiographs obtained at any time during this episode of TB showed a cavity or cavities, was noncavitary consistent with TB, or was noncavitary not consistent with TB.
If Abnormal (status of disease)	Indicates the status of the disease, as follows: **Stable** **Worsening** **Improving** **Unknown**	If abnormal, also indicate if a series of chest radiographs initially show the disease to be stable, worsening, or improving. (See Guidelines, below for information about updating the chest X-Ray.)

Additional guidelines for entering Chest X-Ray information

Updating the chest X-Ray: Do not update chest radiograph information throughout the course of patient follow-up. For instance, if initial radiographs show the patient's disease to be worsening, but later improving in response to therapy, select **Worsening** on the RVCT form. Do not update **Worsening** to **Improving** in response to therapy. Similarly, do not change an abnormal radiograph to normal because it resolved during therapy.

 **California State**: Update the status of the Chest X-Ray if it was previously unknown. For example, if the results of initial radiographs were unknown but subsequently become known and are stable relative to the first comparison film, update the chest radiograph information to read **Stable**.

Q 22 Tuberculin (Mantoux) Skin Test at Diagnosis, rvct

Indicates the result of the Mantoux (tuberculin, PPD, 5TU) test performed during the diagnostic evaluation.

Entry fields in Q 22 Tuberculin (Mantoux) Skin Test

Field	Description	Entry guidelines
Positive	The patient is probably infected with M. tuberculosis.	Select **Positive** to indicate that the patient is probably infected with M. tuberculosis.
Negative	The results of the skin test were negative for M. tuberculosis.	Select **Negative** to indicate that the skin test did not meet current criteria for a positive test.
Not done	The skin test was not performed	Select **Not done** to indicate that the skin test was not performed.
Unknown	The results of the skin test are not known, or you do not know if the skin test was performed.	Select **Unknown** if it is not known whether the skin test was performed, or if the results are not known.
Millimeters (mm) of induration	Shows the millimeters of induration in the test.	In addition to the above, enter the millimeters of induration. If the available skin test result indicates only that the result was "positive" or "negative," but does not give the millimeters of induration, indicate whether the test is recorded as positive or negative and code the millimeters of induration as "99."
If Negative, was patient anergic (Yes, No, Unknown)	Indicates whether or not the patient was anergic.	If the tuberculin skin test was negative, indicate whether or not the patient was anergic by selecting **Yes**, **No**, or **Unknown**. (See Guidelines, below for information about HIV infection and risk groups.)

Additional guidelines for entering Tuberculin (Mantoux) Skin Test information

Previous Positive Skin Test: If skin testing was not performed during the current diagnostic evaluation because the patient has a history of a past positive tuberculin skin test, AND the previous positive test is documented in the medical record, the previous positive test result may be reported. Patient self-report of a previous positive PPD is not acceptable. A history of a previous negative tuberculin skin test, whether documented or not, and a patient self-report of a negative previous or current skin test are also not acceptable.

HIV and Risk Groups: Persons with HIV infection should be evaluated for delayed-type hypersensitivity (DTH) anergy in conjunction with PPD testing. Anergy testing should also be considered for persons who are among risk groups for tuberculous and HIV co-infection but who refuse HIV testing. These risk groups may include, but are not limited to: injecting drug users; persons in correctional facilities; homeless persons; and persons born in countries of high TB or HIV prevalence. The risk of co-infection in these groups may vary in different areas; this variation should be considered in making decisions about anergy testing in persons with unknown HIV status.

Q 23 HIV Status (not applicable in California), rvct

California State: California does not include human immunodeficiency virus (HIV) status in its reporting requirements. **Do NOT** provide the data for Question 23. **Please leave Question 23 blank**.

Note: You must, however, answer the California specific question in the RVCT User Fields: Q C1 HIV Testing Offered, rvct pg 4 and Q C2 AIDS Match and HARS Number, rvct pg 4.

Q 24 Homeless Within Past Year, rvct

Indicates whether the patient was homeless at any time during the 12 months prior to the time when the TB diagnostic evaluation was performed.

Entry fields in Q 24 Homeless Within Past Year

Field	Description	Entry guidelines
No	Indicates that the patient was homeless within the past year.	Select **Yes** if the patient was homeless at any time during the 12 months prior to the time when the TB diagnostic evaluation was performed. (See the definition of "homeless person" in Guidelines, below. Also includes California-specific guidelines.)
Yes	Indicates that the patient was not homeless within the past year.	Select **No** if the patient was not homeless in the past year.
Unknown	It is not known whether the patient was homeless within the past year.	Select **Unknown** if it is not known whether the patient was homeless in the past year.

Additional guidelines for entering Homeless Within Past Year information

California State: Please try to ascertain whether or not the person was homeless. An interview with the patient and or a review of medical records should be attempted. A blank or a value of unknown in this field makes analyses of the patient population difficult.

A homeless person may be defined as:

- An individual who lacks a fixed, regular, and adequate nighttime residence;

  or

- An individual who has a primary nighttime residence that is:
  - A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

    or

  - An institution that provides a temporary residence for individuals intended to be institutionalized;

    or

  - A public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings.
- A homeless person may also be defined as a person who has no home, e.g., is not paying rent, does not own a home, and is not steadily living with relatives or friends. Another definition is a person who lacks customary and regular access to a conventional dwelling or residence. Included as homeless are persons who live on streets or in nonresidential buildings. Also included are residents of homeless shelters, shelters for battered women, welfare hotels, and single room occupancy (SRO) hotels which are not designated for permanent long-term housing.

See **References** for definition sources.

Q 25 Resident of Correctional Facility at Time of Diagnosis, rvct

Indicates whether or not the patient was an inmate of a correctional facility at the time when the TB diagnostic evaluation was performed.

Entry fields in Q 25 Resident of Correctional Facility at Time of Diagnosis

Field	Description	Entry guidelines
No	Indicates that the patient was not an inmate of a correctional facility at the time of TB diagnosis.	Select **No** if the patient was not an inmate of a correctional facility when the TB diagnostic evaluation was performed.
Yes	Indicates that the patient was an inmate of a correctional facility at the time of TB diagnosis.	Select **Yes** if the patient was an inmate of a correctional facility at the time when the TB diagnostic evaluation was performed.
Unknown	Indicates that the type of facility is unknown, or that it is not known if the patient was an inmate at the time of TB diagnosis.	Select **Unknown** if it is not known if the patient was an inmate when the TB diagnostic evaluation was performed. Select **Unknown** if the patient was an inmate, but the type of correctional facility is not known.
If Yes, select type of correctional facility **For CA State**: Enter two-digit county code of the local jurisdiction where jail is located.	Indicates the type of correctional facility in which the patient was an inmate at the time of TB diagnosis.	If **Yes**, indicate the type of institution (see Guidelines, below). The choices are: **Federal Prison, State Prison, Local Jail (Jurisdiction), Juvenile Correctional Facility, Other Correctional Facility, Unknown** **Note:** Any questions regarding classification of a specific correctional facility as federal, state, local, juvenile, or other should be referred to the department of corrections within the state. **California State**: For the reporting of a case that was a resident of a local jail at the time of diagnosis, the revised California RVCT includes a space in question 25 to indicate the jurisdiction of the jail. Please enter the two-digit county code of the jurisdiction where the local jail is located (see List of Codes for Local Health Departments).

Additional guidelines for entering Correctional Facility information

Correctional Facility Definitions:

- **A federal prison** is a confinement facility administered by a federal agency.
- **A state prison** is a confinement facility administered by a state agency.
- **A local jail** is a confinement facility usually administered by a local law enforcement agency, intended for adults but sometimes also containing juveniles, which holds persons detained

pending adjudication and/or persons committed after adjudication for sentences of usually a year or less. Temporary holding facilities, or lockups, that do not hold persons after being formally charged in court are excluded. Both city and county jails are included in this category. Federal and state prisoners who are boarded at local jails should be reported as residents of the local jail.

- **A juvenile correctional facility** is a public or private residential facility, including juvenile detention centers, reception and diagnostic centers, ranches, camps, farms, and halfway houses or group homes. The juveniles served by these facilities include those accused or adjudicated as delinquents; status offenders (runaways, truants, or incorrigibles); and those committed or detained for treatment of abuse, dependency, neglect, or other reasons. Juveniles who are boarded at federal or state prisons or local jails should be reported as residents of the sites at which they are boarded.
- **Other correctional facility** includes: federal detention centers run by the Immigration and Naturalization Service, Indian reservation facilities, military stockades and jails, federal Park Police facilities, privately operated state and local correctional facilities, and police lockups (temporary-holding facilities for persons who have not been formally charged in court).

Q 26 Resident of Long-Term Care Facility at Time of Diagnosis, rvct

Indicates whether or not the patient was a resident of a long-term care facility at the time when the TB diagnostic evaluation was performed.

Entry fields in Q 26 Resident of Long-Term Care Facility

Field	Description	Entry guidelines
No	Indicates that the patient was not a resident of a long-term care facility at the time of TB diagnosis.	Select **No** if the patient was not a resident of a long-term care facility when the TB diagnostic evaluation was performed.
Yes	Indicates that the patient was an resident of a long-term care facility at the time of TB diagnosis.	Select **Yes** if the patient was a resident of a long-term care facility at the time when the TB diagnostic evaluation was performed.
Unknown	Indicates that the type of facility is unknown, or that it is not known if the patient was a resident at the time of TB diagnosis.	Select **Unknown** if it is not known if the patient was a resident of a long-term care facility when the TB diagnostic evaluation was performed. Select **Unknown** if the patient was a resident, but the type of long-term care facility is not known.
If Yes, select type of long-term care facility	Indicates the type of long-term care facility in which the patient was an inmate at the time of TB diagnosis.	If **Yes**, indicate the type of facility(see Guidelines, below). The choices are: **Nursing Home, Hospital-based Facility, Residential Facility, Mental Health Residential Facility, Alcohol or Drug Treatment Facility, Other Long-Term Care Facility, Unknown** **Note:** The state licensing agency for Long-Term Care Places (LTCP) can assist in determining the category under which a facility is classified.

Additional guidelines for entering Resident of Long-Term Care Facility information

Long-Term Care Facility Definitions:

- **Nursing home**: A facility having 3 beds or more is classified as a nursing home if it meets one or more of the following criteria:
  - Certified as a skilled nursing facility, or
  - Certified as an intermediate care facility, or
  - Not certified, but licensed as a nursing home, or
  - Identified as a nursing care unit of a retirement center, or
  - Determined to provide nursing or medical care and/or provide supervision over medications that may be self-administered.
- **Hospital-based facility**: A facility having 3 beds or more is classified as hospital-based if it meets one or more of the following criteria:
  - Was identified as such by the Health Care Financing Administration, or

    - Reported itself to be exclusively hospital-based on the ILTCP (Inventory of Long-Term Care Places) questionnaire.
- **Residential facility**: A facility having 3 beds or more is classified as a residential facility if it meets both of the following criteria:
    - Was not classified as a nursing home or hospital-based facility as described above, and
    - Provided personal care or supervision to its residents in addition to room and board (for example, help with bathing, dressing, eating, walking, shopping, or corresponding).
- Included under residential facilities are:
    - Homes for mentally-retarded or developmentally-disabled persons.
    - Board and care homes (such as residential care homes, group homes, homes for the aged, family care homes, adult foster care homes, personal care homes, adult congregate living facilities, residential community care facilities, and domiciliary care homes).
- **Mental health residential facility includes**: State and local mental hospitals, private psychiatric hospitals, non-federal general hospitals with separate psychiatric services, VA medical centers, multiservice mental health organizations with residential treatment programs, and residential treatment centers for emotionally disturbed children. Excluded are other federal psychiatric facilities, such as those of the Department of Defense, Bureau of Prisons, Public Health Service, and Indian Health Service. Also excluded are Indian reservation facilities which are not federal.
- **Alcohol or drug treatment facility** includes only long-term rehabilitation/residential facilities designated for treatment of 30 days or longer. Excluded are: all ambulatory or outpatient facilities, hospital inpatient detoxification units, free-standing residential detoxification units, hospital inpatient units not for detoxification, and short-term rehabilitation/residential units designated for less than 30 days of treatment. The state alcohol and drug treatment agency can assist in determining if a facility is considered residential. Other long-term care facility includes facilities not mentioned above which are designated for treatment of 30 days or longer.

Q 27 Initial Drug Regimen, rvct

Indicates the drug regimen initially prescribed for treatment of the disease and taken for at least two weeks. The two-week requirement should eliminate most of the record updates necessitated by changes in regimen when treatment is begun.

Entry fields in Q 27 Initial Drug Regimen

Field	Description	Entry guidelines
Select one of the following for every drug listed: **Yes** **No** **Unknown**	Indicates the drug regimen prescribed, the drugs are: **Isoniazid** **Rifampin** **Pyrazinamide** **Ethambutol** **Streptomycin** **Ethionamide** **Kanamycin** **Cycloserine** **Capreomycin** **Para-Amino Salicylic Acid** **Amikacin** **Rifabutin** **Ciprofloxacin** **Ofloxacin** **Other**	Select **Yes** if the drug is known to be part of the initial regimen. Select **No** if the drug is known not to be part of the initial regimen. Select **Unknown** if it is not known whether the drug is part of the initial regimen. **Note:** If it is not feasible to determine the initial regimen of at least two weeks duration, record the initial regimen on which the patient was known to have been placed. (See Guidelines, below for information about selecting "**Other**".)

Additional guidelines for entering Initial Drug Regimen information

Do NOT select "other" if the patient is taking pyridoxine (vitamin B6). It is not required to report this vitamin as part of the drug regimen.

California State: If a patient is taking a combination drug such as Rifamate or Rifater, do not select "other" on the RVCT. For Rifamate, mark both Isoniazid and Rifampin; for Rifater, mark Isoniazid, Rifampin and Pyrazinamide.

Note: You must enter a date for Q 28 Date Therapy Started, and Q 37 Reason Therapy Stopped, if you have selected a drug regimen for this question (Q 27).

Q 28 Date Therapy Started, rvct

Indicates the date the patient began therapy for TB or suspected TB.

Entry fields in Q 28 Date Therapy Started

Field	Description	Entry guidelines
Month, Day, and Year	Indicates the date the patient began therapy for TB or suspected TB.	Enter the month, day and year of the date the patient began therapy for TB or suspected TB. The date must be in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**, **YYYYMM01**, **YYYY/MM/01** or **YYYY-MM-01**. See Guidelines for acceptable events on which the date may be based (date of ingestion is the preferred date). A partial date is allowed. If you do not know the exact day, enter "99" for the **Day**. However, the month and year must be valid dates.

Additional guidelines for entering Date Therapy Started information

The date therapy started can be based on the following events:

- **Date patient first ingested medication**, if documented from a medical record, such as hospital or clinic or directly observed therapy record;

or

- **Date medication was first dispensed to patient**, as documented by medical or pharmacy record;

or

- **Date medication was first prescribed to patient** by health care provider, as documented by medical record or by prescription given to patient.

Information: Date of ingestion is the preferred date for this question. If date of ingestion is not known, enter date of dispensation. If neither of those dates is known, enter date of prescription. Patient history without medical documentation is not acceptable.

Note: If an exact date cannot be determined based on the above guidelines, a partial date may be entered in this field. The 2-digit "month" and "year" of the date must be valid values, but "99" may be entered for the 2-digit "day" of the date if the exact day therapy was started is not known. For example, if after following the above guidelines an exact Date Therapy Started cannot be determined, enter "08/99/94" on the form for a patient know to have started therapy in August of 1994. If the month or year therapy started is not known enter "99/99/99" on the form.

California State: The Date Therapy Started and the Date of the Initial Drug Susceptibility Results (Q 33) should be within 30 days of each other. If the time between the Date Therapy Started and the Date of the Initial Drug Susceptibility Results is more than 30 days, please explain in the "Comments" field in the RVCT Follow-Up 1 form.

Q 29 Injecting Drug Use Within Past Year, rvct

Indicates whether or not the patient has engaged in injecting drug use within the past year. The purpose for collecting this information is to assess the patient's ability to adhere to antituberculosis drug therapy. Use of injecting drugs within the past year should be sought as an indicator of recent activity (e.g., when did the patient last inject drugs).

Entry fields in Q 29 Injecting Drug Use Within Past Year

Field	Description	Entry guidelines
No	Indicates that the patient has not injected drugs within the past year.	Select **No** if the patient has not injected drugs within the past 12 months. (See Guidelines for criteria for determining injected-drug use.)
Yes	Indicates that the patient has injected drugs within the past year.	Select **Yes** if it is known that the patient injected drugs within the past 12 months. (See Guidelines for criteria for determining injected-drug use.)
Unknown	Indicates that it is not known if the patient has injected drugs within the past year.	Select **Unknown** if it is not known if the patient injected drugs within the past 12 months.

Additional guidelines for entering Injecting Drug Use Within Past Year information

Criteria for determining injecting drug use:

- Injecting drug use involves the use of hypodermic needles and syringes for injection of drugs not prescribed by a physician. Route of administration may be intravenous, subcutaneous (skin popping), or intramuscular. Drugs injected may include: heroin or other opiates (demerol, dilaudid), cocaine, heroin and cocaine (speedball), amphetamines or other stimulants, PCP, LSD, or other hallucinogens, barbiturates, steroids or other hormones, other drugs or unknown drugs.
- Medical documentation or other indices of a history of enrollment in a drug treatment program (e.g., methadone detoxification, methadone maintenance, outpatient drug free, residential or inpatient, halfway house, prison or jail treatment, narcotics anonymous, cocaine anonymous, or other self help), medical or laboratory documentation of injecting drug use (e.g., urine testing, if done), or physical evidence (e.g., needle tracks) may be useful in answering this question.

Note: Since the patient interview for injecting drug use is often negative initially, it may be necessary to inquire of the patient at multiple visits and consider urine toxicology.

California State: Please try to ascertain whether or not the person used injecting drugs within the past year. An interview with the patient and /or a review of medical records should be attempted. A blank or a value of unknown in this field makes analyses of the patient population difficult.

Q 30 Non-Injecting Drug Use Within Past Year, rvct

Indicates whether or not the patient as used non-injecting drugs within the past year. The intent of this question is not to require a detailed systematic interview of each patient but to identify those patients whose drug use might interfere with their ability to complete antituberculosis drug therapy.

Note: Alcohol is not included as a drug in this section.

Entry fields in Q 30 Non-Injecting Drug Use Within Past Year

Field	Description	Entry guidelines
No	Indicates that the patient did not use non-injecting drugs within the past year.	Select **No** if the patient did not use non-injecting drugs within the past 12 months. (See Guidelines for criteria for determining non-injected drug use.)
Yes	Indicates that the patient has used non-injecting drugs within the past year.	Select **Yes** if it is known that the patient used non-injecting drugs within the past 12 months. (See Guidelines for criteria for determining non-injected drug use.)
Unknown	Indicates that it is not known if the patient has used non-injecting drugs within the past year.	Select **Unknown** if it is not known whether the patient used non-injecting drugs within the past 12 months.

Additional guidelines for entering Non-Injecting Drug Use Within Past Year information

Information: The purpose for collecting this information is to assess the patient's ability to adhere to antituberculosis drug therapy. Use of non-injecting drugs or illicit drugs within the past year should be sought as an indicator of recent activity (e.g., when did the patient last use non-injecting drugs).

Criteria for determining non-injecting drug use:

- Non-injecting drug use involves the use of licensed or prescription drugs or illegal drugs that were not injected and were not prescribed by a physician. The drugs may be ingested, inhaled, or smoked. Non-injected drugs may include: Heroin or other opiates (demerol, codeine, dilaudid, or non-prescription methadone), cocaine (snorting), crack (smoking cocaine), ingested amphetamines (speed, uppers, bennies), ice or glass (smoking amphetamine), Valium or other benzodiazepams, PCP, LSD, or other hallucinogens, barbiturates, marijuana, hashish, or THC (weed, grass, reefers), nitrites (poppers, rush, hardware), inhalants (gasoline, spray paint), steroids, other drugs, or unknown drugs.
- A history of enrollment in a drug treatment program (e.g., outpatient drug free, residential or inpatient, halfway house, prison or jail treatment, cocaine anonymous, or other self help), as well as medical or laboratory documentation of drug use (e.g., urine toxicology), may be useful in answering this question.

Note: Since the patient interview for non-injecting drug use is often negative initially, it may be necessary to inquire of the patient at multiple visits and consider urine toxicology.

California State: Please try to ascertain whether or not the person used non-injecting drugs within the past year. An interview with the patient and /or a review of medical records should be attempted. A blank or a value of unknown in this field makes analyses of the patient population difficult.

Q 31 Excess Alcohol Use Within Past Year, rvct

Indicates whether or not the patient has engaged in excessive alcohol use within the past year. This information is intended to assess the ability of the patient to adhere to antituberculosis drug therapy.

Excessive use of alcohol within the past year should be sought as an indicator of recent activity (e.g., when did the patient last have a drink). Since the patient interview for excess alcohol use is often negative initially, it may be necessary to inquire of the patient at multiple visits.

Entry fields in Q 31 Excess Alcohol Use Within Past Year

Field	Description	Entry guidelines
No	Indicates that the patient did not use excess alcohol within the past year.	Select **No** if the patient has not used alcohol to excess within the past 12 months. (See Guidelines for criteria for determining excess alcohol use.)
Yes	Indicates that the patient has used excess alcohol within the past year.	Select **Yes** if the patient has used alcohol to excess within the past 12 months. (See Guidelines for criteria for determining excess alcohol drug use.)
Unknown	Indicates that it is not known if the patient has used excess alcohol within the past year.	Select **Unknown** if it is not known if the patient used alcohol to excess within the past 12 months.

Additional guidelines for entering Excess Alcohol Use Within Past Year information

Criteria for determining excess alcohol use:

- Reliable indicators of excess alcohol use include participation in Alcoholics Anonymous or alcohol treatment programs (e.g., outpatient, residential or inpatient, halfway house, prison or jail treatment, or other self help). There are also numerous screening instruments that can be helpful in identifying persons who may use alcohol to excess (see **References**.)
- A multiple option approach to identifying excess alcohol use may also be useful, and includes: (a) a description by the patient, the patient's family or acquaintances, or a health care provider of chronic, high intake of alcohol with behavior associated with alcohol abuse; or (b) repeated visits to health care facilities during which alcohol intoxication was observed; or (c) report of alcohol use coupled with the existence of organic, alcohol-associated disease (e.g., pancreatitis, cirrhosis); or (d) a diagnosis of alcoholism on available medical records (e.g., discharge summaries or medical referral information).

California State: Please try to ascertain whether or not the person used excessive amounts of alcohol within the past year. An interview with the patient and/or a review of medical records should be attempted. A blank value or value of unknown in this question makes analyses of the patient population difficult.

Q 32 Occupation, rvct

Indicates the patient's employment and occupation within the past 24 months.

Entry fields in Q 32 Occupation

Field	Description and Entry Guidelines
Select all that apply within the past 24 months. If a patient performed an occupation described below in the setting of another occupation described below, check both appropriate boxes. For example, if the patient is a physician who has worked in both a hospital setting and a prison medical clinic, check both "Health Care Worker" and "Correctional Employee".	
Health Care Worker	**Health Care Worker** includes any person who has worked in a medical facility (e.g., hospital, clinic, health maintenance organization, infirmary, dispensary, long-term care facility, dental office, drug treatment center, medical laboratory, morgue, etc.) within the 24 months before the TB diagnostic evaluation was performed. Also included are students, trainees and volunteers who spend time in a health care facility, as well as persons who deliver health care in the community (e.g., public health nurse, visiting nurse, outreach worker, etc.).
Correctional Employee	**Correctional Employee** includes any person who has worked in a correctional facility. The facility may be a federal or state prison, local jail, juvenile correctional facility, or other correctional facility (see variable on correctional institution, Q 25).
Migratory Agricultural Worker	**Migratory Agricultural Worker** includes any individual whose principal employment is in agriculture on a seasonal basis, and who establishes for the purpose of such employment a temporary place of abode. Excluded are seasonal agricultural workers who are not migratory agricultural workers.
Other Occupation	**Other Occupation** includes any person who has been employed for pay or outside the home at any job within the 24 months before the TB diagnostic evaluation was performed.
Not Employed within Past 24 Months	**Not Employed within Past 24 Months** includes any person who was not employed for pay or outside the home during the entire 24 months before the TB diagnostic evaluation was performed (e.g., student, retiree, homemaker, unemployed, institutionalized).
Unknown	Select **Unknown** if the employment history of the patient during the 24 months prior to the initiating of the TB diagnostic evaluation is not known.

Additional guidelines for entering Occupation information

California State: Please try to ascertain whether or not the person was employed within the past 24 months and what their occupation was. Do not assume that the person is unemployed if they are a recent arrival from another country, an immigrant, a refugee, or an undocumented person. The purpose of this question is to determine whether there are identifiable sites of employment, occupations, or working conditions which pose a greater risk of tuberculosis transmission. An interview with the patient and/or a review of medical records should be attempted. A blank or a value of unknown in this field makes analyses of the patient population difficult.

C1 - C3 - RVCT CA User Defined Questions and Variables (data fields)

California User Defined Variables for TIMS

This topic describes the user-defined variables that are specific to the **California** RVCT and Follow-Up 2 Report forms.

Note on user-defined variables and how they work in the TIMS software: These California variables have been added to the standard CDC RVCT and Follow Up 2 Reports as implemented in the CDC TIMS TB reporting software. If you are a TIMS user, the following will occur:

TIMS specific action: The User screens for each module will pop up automatically upon initiating a new case. If you wish to add/edit information in a User Field at a later date, you must pull up the screen by clicking on the "paper" icon. (In the Client screen this icon appears in the upper right corner; in RVCT and Follow-up 2 screens it appears in the lower left corner.) Exit by clicking on "Save" (data will be saved), or by clicking on the "X" in the upper right of the User screen (data will not be saved).

California User-Defined Variables on the RVCT Form

Report Date (Required) (see Q 05 Date Reported, rvct)

This is the date the health department first became aware that the patient might have tuberculosis. It should correspond to the "Month-Year Reported" variable in the Client module. However, note that unlike the field for "Month-Year Reported", this field must contain the month, day and year that the health department first became aware of the case. If the patient has had a previous diagnosis of tuberculosis, the month/day/year applies to the current episode. Both the "Month-Year Reported" in the Client module, and the "Report Date" in the user fields must be completed.

Variable format: MM/DD/YYYY

Variable size: 8

Count Date (Required) (see Q 06 Date Counted, rvct)

This field indicates the month/day/year the health department verified the case as TB and included it in the official case count. It should correspond to the field "Month-Year Counted" in the RVCT module. However, note that unlike the "Month-Year Counted" on the initial RVCT, this field must contain the month, day and year that the case was verified and included in the official case count. You must assign a count date in order for the case to be included in the official case count for any given year.

Variable format: MM/DD/YYYY

Variable size: 8

Was HIV testing offered during the course of TB evaluation or treatment? (Required) (see Q C1 HIV Testing Offered, rvct)

Check 0 – No, if HIV testing was not offered

Check 1 – Yes, if HIV testing was offered

Check 9 – Unknown, if it is not known whether the patient was offered HIV testing

Offering HIV testing is defined as discussing with the TB patient the purpose of HIV testing and the availability of voluntary HIV testing. Do not indicate HIV status or enter HIV test results on the RVCT form or in the Comments field.

Variable format: Character

Variable size: 1

AIDS match (Required) (see Q C2 AIDS Match and HARS Number, rvct)

"AIDS Match Performed" is a required field and must be completed for every patient. For each reported case of TB, a match with the local AIDS registry must be performed.

Check 1 if the AIDS registry match was performed and the HARS* number was found

Check 2 if the AIDS registry match was performed and no HARS* number was found

Check 3 if the AIDS registry match is pending

Check 4 if no AIDS registry match was performed

Check 9 if it is unknown whether an AIDS registry match was performed

The local AIDS registry should be consulted to perform a TB/AIDS registry match for each newly verified case of TB. Contact the AIDS surveillance unit in your health department to establish the TB/AIDS registry match protocol. Tab 3, Attachment 2 of this manual contains the letter from the California Department of Health Services Office of AIDS authorizing the local health department TB/AIDS registry match and the release of HARS case numbers from the local AIDS case registry to the local TB case registry.

Do not delay completion and transmission of the RVCT form if the result of the AIDS Registry match is not available when the initial RVCT case report is submitted. Update the AIDS Registry match variable when the result becomes available.

Variable format: Character

Variable size: 1

HARS=HIV/AIDS Registry System (see Q C2 AIDS Match and HARS Number, rvct)

State HARS HIV/AIDS patient number

Provide the state HARS number for all patients for whom a HARS number has been found in the AIDS registry match.

Variable format: Character

Variable size: 7

Jurisdiction of County Jail (see Q 25 Resident of Correctional Facility at Time of Diagnosis, rvct)

If the patient was a resident of a local jail (RVCT Q25 is marked yes), enter the two digit county code of the jurisdiction where the local jail is located (see RVCT Form Completion - California LHJ Codes for Local Health Jurisdiction codes). For example, if a person is diagnosed as having TB in a Los Angeles County jail but is a permanent resident of Orange County, Orange County should count the case and enter '70' (Los Angeles County) into this field.

Variable format: Character

Variable size: 2

California User-Defined Variables on the Follow Up-2 (Case Completion) Form

Destination Jurisdiction (Required for patients who move) (see Q 37 Reason Therapy Stopped, fu 2)

If a patient moves out of your jurisdiction to another jurisdiction in California (you have a forwarding address and phone number and RVCT Q37 reads moved), enter the two digit code for that California jurisdiction (see RVCT Form Completion - California LHJ Codes for Local Health Jurisdiction codes). If a patient moves to another state or out of the country, enter the full name of the state or country in this field. For example, if a patient moves to San Francisco, enter '90' into this field. If a patient moves to New Mexico, enter 'New Mexico' into this field. If a patient moves to China, enter 'China' into this field. Do not put any other information into this field.

Variable format: Character

Variable size: 15

Q C1 HIV Testing Offered, rvct

Indicates whether or not HIV testing was offered to the patient. Offering HIV testing is defined as discussing with the TB patient the purpose of HIV testing and the availability of voluntary HIV testing. **Do not** indicate HIV status or enter HIV test results on the RVCT form or in the Comments field (Q C3).

Q C1 HIV Testing Offered is a user-defined field for the California RVCT. It does not apply to other states.

Entry fields in Q C1 HIV Testing Offered

This is a required question, you must enter data in all appropriate fields. The RVCT form will not be accepted if this question is blank.

Field	Description	Entry guidelines
No	Indicates that HIV testing was not offered to the patient.	Select **No** if HIV testing was not offered
Yes	Indicates that HIV testing was offered to the patient.	Select **Yes** if HIV testing was offered
Unknown	Indicates that it is not known if HIV testing was offered to the patient.	Select **Unknown** if it is not known whether the patient was offered HIV testing

Additional guidelines for entering HIV Testing Offered information

Offering HIV testing is defined as discussing with the TB patient the purpose of HIV testing and the availability of voluntary HIV testing. Voluntary HIV counseling and testing for all TB cases and suspect cases is recommended by the Centers for Disease Control and Prevention (CDC), the California Tuberculosis Controllers Association, and the California Department of Health Services.

An HIV test should be performed, with informed consent, at the time of diagnosis for all patients suspected of having TB, as both treatment and prognosis may be significantly impacted by HIV infection. (CDHS/CTCA Joint Guidelines for the Treatment of Active Tuberculosis Disease, April 15, 2003).

Important: **Do not** indicate HIV status or enter HIV test results on the RVCT form or in the **Comments** field (Q C3).

Information: See RVCT Report - Form Completion Instructions - HIV and AIDS for important information about confidentiality requirements.

Q C2 AIDS Match and HARS Number, rvct

"AIDS Match Performed" is a **required** question and must be completed for every patient. For each reported case of TB, a match with the local AIDS registry must be performed.


Q C2 AIDS Match and HARS Number is a user-defined field for the California RVCT. It does not apply to other states.

Entry fields in Q C2 AIDS Match and HARS Number

This is a required question, please enter data in all appropriate fields.

Field	Description	Entry guidelines
AIDS registry match was performed and the AIDS number *was* found	Indicates that the AIDS registry match was performed and that the AIDS number was found.	Select this field if the AIDS registry match **was** performed and the HARS number was found (HARS=HIV/AIDS Registry System).
AIDS registry match was performed and AIDS number was *not* found	Indicates that the AIDS registry match was performed and that the AIDS number was not found.	Select this field if the AIDS registry match was performed and no HARS number was found (HARS=HIV/AIDS Registry System).
Registry match is pending	Indicates that the AIDS registry match is pending.	Select this field if the AIDS registry match is pending.
AIDS registry match was *not* performed	Indicates that the AIDS registry match was not performed.	Select this field if an AIDS registry match was not performed.
Unknown	Indicates that it is unknown whether an AIDS registry match was performed.	Select this field if it is unknown whether an AIDS registry match was performed.
If AIDS match was found, provide the State HARS HIV/AIDS patient number	Indicates the state HARS number if one is found for the patient in the AIDS registry match.	Provide the state HARS number for all patients for whom a HARS number has been found in the AIDS registry match (HARS=HIV/AIDS Registry System), or for whom the HARS number was known prior to doing the AIDS Registry match.

Additional guidelines for entering AIDS Match and HARS Number information

The local AIDS registry should be consulted to perform a TB/AIDS registry match for each newly verified case of TB. Contact the AIDS surveillance unit in your health department to establish the TB/AIDS registry match protocol.

Do not delay completion and transmission of the RVCT form if the result of the AIDS Registry match is not available when the initial RVCT case report is submitted. Update the AIDS Registry match variable when the result becomes available.

Information: See CDHS Policy Letter for AIDS HARS Case Numbers for a copy of the letter from the California Department of Health Services Office of AIDS authorizing the local health department TB/AIDS registry match and the release of HARS case numbers from the local AIDS case registry to the local TB case registry.

Confidentiality requirements: See RVCT Report - Form Completion Instructions - HIV and AIDS for important information about confidentiality requirements.

Q C3 Comments, rvct

Additional space is provided at the bottom of the RVCT form to write comments clarifying any entries in the RVCT report. Comments that you enter are reviewed by the CDHS-TBCB Registry staff. You may use the Comments field to call their attention to important information about the specific case or patient.


Q C3 Comments is a user-defined field for the California RVCT. It does not apply to other states.

Entry fields in Q C3 Comments

Field	Description	Entry guidelines
Comments	Any comments that the person filling out the form wishes to enter.	Enter any comments that you wish in this field.

33 - 34 - Follow Up-1 Questions (data fields)

Q 33 Initial Drug Susceptibility Results, fu 1

Indicates whether or not initial drug susceptibility testing was done.

Entry fields in Q 33 Initial Drug Susceptibility Results

Warning: If the answer below is **No** or **Unknown**, **do not** complete the remainder of the Follow Up 1 form. However, you may enter Comments if you wish (the Comments field is at the bottom of the form).

Field	Description	Entry guidelines
Was drug susceptibility testing done? **No** **Yes** **Unknown**	Indicates whether or not drug susceptibility testing was done (or if it is not known whether the testing was done)	Select **Yes** if the patient has any isolate upon which drug susceptibility testing was performed. Select **No** if no susceptibility testing was performed. Select **Unknown** if it is not known whether susceptibility testing was performed.
If yes, enter date first isolate collected for which the drug susceptibility was done. **Month Day Year**	Indicates the date the first isolate was collected.	If drug susceptibility testing was done, enter the collection date of the first isolate on which drug susceptibility testing was performed. This information may be available from medical records or laboratory reports. The date must be in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**, **YYYYMM01**, **YYYY/MM/01** or **YYYY-MM-01**. A complete date is required. Partial dates are not acceptable. If the month, day, and year the isolate was collected are not all known, enter "99/99/99" on the form.

Additional guidelines for entering Initial Drug Susceptibility Results information

California State: Be sure you report the date the specimen was collected from the patient. This is different from the date the specimen might have been sub-cultured for drug susceptibility testing. If the time between date therapy started and the date of the initial drug susceptibility results is more than 30 days, please explain in the "Comments" field (Q 34) of the RVCT Follow-Up 1 form.

Q 34 Susceptibility Results, fu 1

Indicates the results of first-isolate susceptibility testing on specific drugs. Also indicates if testing was done for a specific drug.

Entry fields in Q 34 Susceptibility Results

Field	Description	Entry guidelines
Susceptibility Results (for each drug listed) **Resistant** **Susceptible** **Not Done** **Unknown**	The drugs on the selection list are: **Isoniazid** **Rifampin** **Pyrazinamide** **Ethambutol** **Streptomycin** **Ethionamide** **Kanamycin** **Cycloserine** **Capreomycin** **Para-Amino Salicylic Acid** **Amikacin** **Rifabutin** **Ciprofloxacin** **Ofloxacin** **Other**	**Select the results of first-isolate susceptibility testing for each drug listed**: Select **Resistant** if there was any degree of resistance, even partial resistance or resistance at a low concentration of the drug. Select **Susceptible** only if completely susceptible. Select **Not done** if susceptibility testing was not done for this drug. Select **Unknown** if it is not known whether the test was performed or the results were unavailable. **Note:** For **Other** drugs include only antituberculosis drugs; do not include pyridoxine (vitamin B6).
Comments	Space for comments regarding the drug susceptibility testing.	If desired, enter comments regarding the case of tuberculosis reported on the Initial Drug Susceptibility Report (e.g., name of the laboratory that performed drug susceptibility testing, etc.).

Additional guidelines for entering Susceptibility Resultsinformation

California State: Drug susceptibility testing is required if a specimen is available. The local health department should try to ensure that the health care provider collects and submits a specimen for drug susceptibility testing. The local health department should obtain information from the laboratory doing the drug susceptibility test results, if the results are not available from the health care provider.

California State: Whenever **second-line** drug susceptibility testing is done on a patient's initial sputum specimen, these results should be reported on the RVCT Follow Up 1, as long as the testing was performed on the same specimen, or on a specimen collected with 7 days of the initial specimen, provided they have the same first-line susceptibility pattern as seen on the original specimen. If the Follow Up 1 has already been submitted to the TBCB, the additional susceptibility results should be updated on the Follow Up 1 Report (a new Follow Up 1 report submitted).

35 - 41 - Follow Up-2 Questions (data fields)

Q 35 Sputum Culture Conversion Documented, fu 2

Provides information on sputum culture conversion only for patients with initially positive sputum cultures.

Important: **Do not** complete this question if the patient was not sputum culture **positive**, as indicated on Q 18 Sputum Culture, rvct pg 2. **Do not** complete this question for patients without initially positive sputum cultures who have positive cultures from other pulmonary specimens (e.g., bronchoscopy fluid).

Entry fields in Q 35 Sputum Culture Conversion Documented

Field	Description	Entry guidelines
No	Indicates patient with initially positive sputum culture had no subsequent negative sputum cultures.	Select **No** if a patient with an initially positive sputum culture had no subsequent negative sputum cultures (e.g., all follow-up cultures were positive, patient could not produce sputum after therapy started, or no follow-up sputum cultures obtained).
Yes	Indicates patient had an initially positive sputum culture followed by one or more consistently negative cultures.	Select **Yes** if a patient had an initially positive sputum culture followed by one or more consistently negative sputum cultures.
If Yes, Date Specimen Collected on Initial Positive Sputum Culture **Month Day Year**	Indicates date specimen collected on initial positive culture.	Enter a date only for patients who had one or more positive sputum cultures and who subsequently had one or more negative cultures documented. This information may be available from medical records or laboratory reports. A complete date is required. Partial dates are not acceptable. If the month, day, and year the first consistently negative sputum culture was obtained are not all known, enter "99/99/99". The date must be in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**, **YYYYMM01**, **YYYY/MM/01** or **YYYY-MM-01**.
If Yes, Date Specimen Collected on First Consistently Negative Culture **Month Day Year**	Indicates date specimen collect on first consistently negative culture.	Enter a date only for patients who had one or more positive sputum cultures and who subsequently had at least one documented negative culture. This date should be at least 1 week after the last positive culture was obtained. There should be no positive cultures after this date. This information may be available from medical records or laboratory reports. A complete date is required. Partial dates are not acceptable. If the month, day, and year the first consistently negative sputum culture was obtained are not all known, enter "99/99/9999". The date must be in a valid date format, for example: **YYYY-MM-DD**, **YYYY/MM/DD**, **YYYYMMDD**,

Field	Description	Entry guidelines
		YYYYMM01, **YYYY/MM/01** or **YYYY-MM-01**.
Unknown	Indicates that results are unknown or you do not know if follow-up cultures were collected.	Select **Unknown** if the results of all follow-up cultures are unknown, or if it is not known if follow-up cultures were obtained.

Additional guidelines for entering Sputum Culture Conversion Documented information

 **California State**: Do not include any of the very first sputa that were taken from the patient for use as the first consistently negative culture date. For example, if a patient initially produced 3 sputum samples and any one of these was negative, do not use one of these sample dates in this field. The first consistently negative culture must be at least one week after the last positive culture was obtained.

Q 36 Date Therapy Stopped, fu 2

Indicates the date the patient stopped taking therapy for TB or suspected TB. (See Guidelines, below, for more information about this question.)

California State: See RVCT Report - Form Completion Instructions - Administrative Closure of TB Cases for instructions on assigning therapy stop dates for cases who have been administratively closed.

Entry fields in Q 36 Date Therapy Stopped

Field	Description	Entry guidelines
Month Day Year	Indicates the date the patient stopped taking therapy for TB or suspected TB.	Enter the month, day and year of the date the patient stopped taking therapy for TB or suspected TB. If an exact date cannot be determined based on the Guidelines below, a partial date may be entered. The 2-digit "month" and "year" of the date must be valid values, but "99" may be entered for the 2-digit "day" of the date if the exact day therapy was stopped is not known. (For example, if after following the Guidelines an exact Date Therapy Stopped cannot be determined, enter "08/99/94" on the form for a patient know to have started therapy in August of 1994. If the month or year therapy stopped is not known enter "99/99/99" on the form.)

Additional guidelines for entering Date Therapy Stopped information

The time period represented by the interval between Q 28 Date Therapy Started and Date Therapy Stopped is meant to encompass the entire period (including interruptions in therapy) that the patient was receiving medication to treat TB disease or suspected TB. Treatment with anti-TB medications of disease caused by mycobacteria other than M. tuberculosis complex should not be included in the time period from Date Therapy Started to Date Therapy Stopped.

Consider the following: A patient with suspected TB starts therapy on March 13, 1994. The culture obtained at the time of the diagnostic evaluation is returned on April 12, 1994 having grown M. avium. If therapy is continued to treat the M. avium, Date Therapy Stopped should still be completed to reflect that treatment for TB was stopped because TB disease was ruled out. In this example, Date Therapy Stopped should be April 12, 1994. Alternatively, the date that the laboratory identified the organism as not M. tuberculosis complex should be used.

Basis for the date therapy stopped:

For patients being treated for TB disease or suspected TB, Date Therapy Stopped should be completed as outlined below:

- Date that the patient last ingested medication; **or**
- Date that the medication dispensed to the patient would have run out, if the patient had taken all the medication; **or**
- Date that the medication prescribed to the patient would have run out, if the patient had taken all the medication from the date of prescription.
- **Date of last ingestion is the preferred date for this question**. If date of ingestion is not known, enter the date that the medication would have run out, based on the date of dispensation. If neither of the above dates is known, enter the date that the medication would have run out based on the date of prescription. While there may be interruptions in antituberculosis drug therapy, the final date when the patient took medication for TB disease or suspected TB should be given. Date Therapy Stopped should be updated if a patient is lost to follow-up and then returns and completes therapy. Patient history without medical documentation is not acceptable.

Q 37 Reason Therapy Stopped, fu 2

Indicates the primary reason that therapy was ended and not resumed. This question should be completed when the case is closed. If the case is reopened (e.g., patient lost to follow up is found, restarts therapy, and completes therapy), the Case Completion Report (Follow Up 2 form) should be updated (e.g., to reflect that the patient completed therapy).

Entry fields in Q 37 Reason Therapy Stopped

Field	Description	Entry guidelines
Completed Therapy	Indicates that the patient successfully completed therapy.	Select **Completed** therapy if the patient successfully completed the prescribed course of therapy.
Moved **Destination**	*Moved* indicates that the patient moved before treatment was completed. *Destination* indicates the county, state, or country where the patient moved.	Select **Moved** if the patient moved to another jurisdiction with a known forwarding address before treatment was completed. See RVCT Report - Form Completion Instructions - Patient Movement for surveillance data requirements for persons with TB who move from one reporting area to another. (Also see Q 04 Address for Case Counting: Transfer cases for information about counting transferred cases.) **California State**: If a patient moves out of your jurisdiction to another jurisdiction in California before completing therapy (you have a forwarding address and phone number and you've selected "Moved"), enter the two-digit code for that California jurisdiction (see list of California Local Health Jurisdiction codes). If a patient moves to another state or out of the country, enter the full name of the state or country in this field. For example, if a patient moves to San Francisco, simply enter '90' into this field. If a patient moves to New Mexico, enter 'New Mexico' into this field. If a patient moves to China, enter 'China' into this field. Do not put any other information into this field. See RVCT Report - Form Completion Instructions - Patient Movement for detailed information about patient movement and transfers.
Lost	Indicates that the patient cannot be located prior to the completion of treatment	Select **Lost** if the patient cannot be located prior to the completion of treatment (e.g., the patient moved to an unknown location)
Uncooperative or refused	Indicates that the patient refused to complete therapy.	Select **Uncooperative or refused** if the patient refused to complete therapy (e.g., stopped taking drugs). If patient restarts treatment, the Case Completion Report form report should be updated as appropriate.

Field	Description	Entry guidelines
Not TB	Indicates that the completed diagnostic evaluation determined that the diagnosis of TB is not substantiated.	Select **Not TB** if the completed diagnostic evaluation determined that the diagnosis of TB is not substantiated (e.g., M. avium is isolated from a clinical specimen).  **California State**: See RVCT Report - Form Completion Instructions - Patient Movement for complete instructions on RVCT reporting of "Not TB" cases.
Died	Indicates that the patient died before therapy was completed.	Select **Died** if the patient died before therapy was completed.
Other	Indicates that therapy was discontinued for another reason.	Select **Other** if therapy was discontinued for another reason.
Unknown	Indicates that the reason that therapy stopped is not known.	Select **Unknown** if the reason that therapy stopped is not known.

Additional guidelines for entering Reason Therapy Stopped information

 **California State**: In some cases, a health department may elect to administratively close the record of a patient who remains on anti-TB treatment. See RVCT Report - Form Completion Instructions - Administrative Closure of TB Cases for the policy and reporting instructions for this group of patients.

Q 38 Type of Health Care Provider, fu 2

Indicates the type of health care provider(s) involved in the care of the patient.

Entry fields in Q 38 Type of Health Care Provider

Field	Description	Entry guidelines
Health Department	Indicates that all patient care was provided by the Health Department.	Select **Health Department** if all outpatient care was provided by the state or local health department (e.g., TB program, primary care clinics, field nurses, outreach workers, etc.).
Private / Other	Indicates that all patient care was provided by a private and/or other providers.	Select **Private / Other** if all care (except for contact investigation and dispensing of medication) was provided by non-health-department providers, such as: private providers, hospital, correctional institution, long-term care facility, federal program, Veteran's Administration, alcohol or drug treatment programs, or other health care providers that are not part of the state or local health department.
Both Health Department and Private / Other	Indicates that the patient was cared for by both the Health Department and private providers.	Select **Both Health Department and Private / Other** if both sectors were involved in care of the patient (e.g., private provider cares for patient who receives diagnostic tests and/or directly observed therapy from the health department, etc.). Also select **Both Health Department and Private / Other** if the patient was initially under health department care and was subsequently under private/other care (or vice versa).

Additional guidelines for entering Type of Health Care Provider information

There are no additional guidelines for this question.

Q 39 Directly Observed Therapy, fu 2

Directly observed therapy (**DOT**) or supervised therapy involves the direct visual observation by a health care provider (e.g., outreach worker or nurse) or other reliable person (e.g., homeless shelter worker) of a patient's ingestion of medication. Delivering medication to a patient without visual confirmation of ingestion does not constitute DOT.

Confirmation that the medication has been swallowed may sometimes be necessary. Using such techniques as having the patient swallow a glass of water or talk following ingestion, inspecting the oral cavity with the tongue raised by the patient, or using a tongue blade to inspect between the cheek and the gums are helpful in determining if the medication has been swallowed. DOT regimens may be administered daily, three times a week, or twice weekly.

Entry fields in Q 39 Directly Observed Therapy

<table>
<tr><th>Field</th><th>Description</th><th>Entry guidelines</th></tr>
<tr><td>No, totally self-administered</td><td rowspan="4">Indicates how DOT was administered.</td><td>Select No, totally self-administered if no doses of medication were given under supervision.</td></tr>
<tr><td>Yes, totally directly observed</td><td>Select Yes, totally directly observed therapy in the following cases:
<table>
<tr><th>Treatment regimen</th><th>Minimum weekly doses given under DOT</th></tr>
<tr><td>Daily regimen</td><td>Five or more doses were administered under DOT each week.</td></tr>
<tr><td>Twice-weekly regimen</td><td>Both doses were administered under DOT each week.</td></tr>
<tr><td>Thrice-weekly regimen</td><td>All three doses were administered under DOT each week.</td></tr>
</table></td></tr>
<tr><td>Yes, both directly observed and self-administered</td><td>Select Yes, both directly observed and self-administered therapy if one or more doses were given under supervision and one or more doses were not. For patients on a daily regimen who receive five or more doses under DOT but self-administer weekend doses, check Yes, totally directly observed therapy. (See "If Yes..." field, below.)</td></tr>
<tr><td>Unknown</td><td>Select Unknown if it is not known whether any doses of medication were given under supervision.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Number of weeks of directly observed therapy</td><td>Indicates the number of weeks that DOT was administered.</td><td>Enter the total number of calendar weeks (Sunday through Saturday) that the patient received the minimum amounts of medication under supervision in clinic or other facility or in the field.
<table>
<tr><th>Treatment regimen</th><th>Number of weeks of directly observed therapy</th></tr>
<tr><td>Daily regimen</td><td>Count the week only if five or more of the week's doses were administered</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Field</th><th>Description</th><th>Entry guidelines</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>under DOT.</td></tr>
<tr><td>Twice-weekly regimen</td><td>Count the week only if both the week's doses were administered under DOT.</td></tr>
<tr><td>Thrice-weekly regimen</td><td>Count the week only if all three of the week's doses were administered under DOT.</td></tr>
</table>
If the patient does not receive the above minimum number of doses under DOT, do not count the week. the number of weeks of DOT indicated must be less than or equal to the number of weeks in the time period between Date Therapy Started (Q 28) and Date Therapy Stopped (Q 36).
</td></tr>
<tr><td colspan="3">If Yes, give site(s) of directly observed therapy: If any medication was administered under DOT, indicate the site(s) of directly observed therapy.</td></tr>
<tr><td>In clinic or other facility</td><td rowspan="4">Indicates the site(s) where DOT was administered.</td><td>Select In clinic or other facility if DOT was given at a health department or private provider facility (e.g., TB clinic, community health center, migrant clinic, drug treatment center, hospital outpatient setting, HIV/AIDS clinic) or at an institution, such as a nursing home or correctional facility.</td></tr>
<tr><td>In the field</td><td>Select In the field if DOT was given solely outside a facility, such as at the patient's home, work, or other site.</td></tr>
<tr><td>Both in facility and in the field</td><td>Select Both in facility and in the field if both were used (e.g., patient received DOT at a clinic and in the field when patient did not show up at the clinic).</td></tr>
<tr><td>Unknown</td><td>Select Unknown if the sites of DOT are not known.</td></tr>
</table>

Additional guidelines for entering Directly Observed Therapy information

There are no additional guidelines for this question.

Q 40 Final Drug Susceptibility Results, fu 2

This question helps assess the frequency of acquired drug resistance.

Entry fields in Q 40 Final Drug Susceptibility Results

Important: If the answer below is **No** or **Unknown**, **do not** complete the remainder of the Follow Up 2 form. However, you may enter Comments if you wish (the Comments field is at the bottom of the form).

Field	Description	Entry guidelines
No	Indicates that follow up drug susceptibility testing was not done.	Select **No** if no follow-up drug susceptibility testing was done.
Yes	Indicates that testing was performed 30 days after the initial testing.	Select **Yes** if drug susceptibility testing was performed on an isolate that was collected ³30 days after the isolate for which initial drug susceptibility testing was performed (Q 33).
Unknown	Indicates that it is not known if follow up drug testing was performed.	Select **Unknown** if it is not known whether follow-up drug susceptibility testing was performed.
If Yes, enter date final isolate collected for which drug susceptibility was done: **Month Day Year**	Indicates the collection date of the last isolate for which drug susceptibility testing was performed.	**Date of final isolate**: If follow-up susceptibility testing was done, indicate the collection date of the last isolate for which drug susceptibility testing was performed. This date should be 30 days or more after the collection date of the initial isolate for which drug susceptibility was done (Q 33). This information is available from medical records or laboratory reports. A complete date is required. Partial dates are not acceptable. If the month, day, and year the isolate was collected are not all known, enter "99/99/99" on the form.

Additional guidelines for entering Final Drug Susceptibility Results information

There are no additional guidelines for this question.

Q 41 Final Susceptibility Results, fu 2

Indicates results for the last isolate for which drug susceptibility testing was performed.

Entry fields in Q 41 Final Susceptibility Results

Field	Description	Entry guidelines
Final Susceptibility Results (for each drug listed) **Resistant** **Susceptible** **Not Done** **Unknown**	The drugs on the selection list are: **Isoniazid** **Rifampin** **Pyrazinamide** **Ethambutol** **Streptomycin** **Ethionamide** **Kanamycin** **Cycloserine** **Capreomycin** **Para-Amino Salicylic Acid** **Amikacin** **Rifabutin** **Ciprofloxacin** **Ofloxacin** **Other**	**Select the results of last-isolate susceptibility testing for each drug listed**: Select **Resistant** if there was any degree of resistance, even partial resistance or resistance at a low concentration of the drug. Select **Susceptible** only if completely susceptible. Select **Not done** if susceptibility testing was not done for this drug. Select **Unknown** if it is not known whether the test was performed or the results were unavailable. For **Other** drugs include only antituberculosis drugs; do not include pyridoxine (vitamin B6).
Comments	Space for comments regarding the drug susceptibility testing.	If desired, enter comments regarding the case of tuberculosis reported on the Case Completion Report (e.g., name of the laboratory that performed drug susceptibility testing, etc.).

Additional guidelines for entering Final Susceptibility Results information

California State: The *CDHS*/*CTCA* Joint Guidelines for TB Case Management state that a patient whose "sputa specimen(s) remain bacteriologically positive after 2 months of treatment or become bacteriologically positive after initially converting to negative" should have additional cultures collected for repeat drug sensitivity testing. The results of this susceptibility testing should be reported on the RVCT Follow Up 2 Report (Case Completion Report). RVCT instructions state that drug susceptibility testing of specimens collected 30 days or more after the specimen used for initial drug susceptibility testing should be reported as final drug susceptibilities (Q 40 and Q 41) on the Follow Up 2 Report.

HIV Testing and AIDS Reporting

RVCT Report - HIV Testing and AIDS Reporting

This **HIV and AIDS** topic provides important instructions and information that are in addition to the primary RVCT form completion instructions. You will need to consider these instructions when you fill out the RVCT and Follow Up Report forms, whether you enter them online, submit them via a data-exchange protocol, or fax them to the CDHS, TBCB Registry. This information relates to the RVCT Questions HIV Testing Offered and AIDS Match and HARS Number (see **C1 - C3 - RVCT CA User Defined Questions and Variables**).

California state: The information on HIV and AIDS confidentiality in this topic applies to the State of California and is a protocol issued by the California Department of Health Services.

May 17, 2006, Important Note on Senate Bill 699 Soto AIDS HIV reporting: Due to the passage of SB 699 (signed by the Governor of California and filed with the State on April 17, 2006) the *Confidentiality of HIV/AIDS Data* section of this topic has been updated to Ver 2.0, effective April 18, 2006. If you have questions about the bill or the new information and how it will affect your RVCT reporting, please email the TB Registry at tbregistry@dhs.ca.gov.

Background

The confidential nature of HIV/AIDS-related information requires that TB programs develop appropriate policies and staff training to assure data security and confidentiality of personal identifying information. California health care programs and providers are mandated to assure the confidentiality of all medical information by the Confidentiality of Medical Information Act, California Civil Code, Section 560. The confidentiality of HIV/AIDS-related records containing personal identifying information is further mandated by California Health and Safety Code, Section 121025 and 120980.

Local health department TB and AIDS programs are urged to work collaboratively to ensure confidentiality and security procedures.

Confidentiality of HIV/AIDS Data

INFORMATION EFFECTIVE: April 18, 2006 (Ver 2.0)

California Department of Health Services, Office of AIDS

HIV/AIDS Case Registry Section

1. Overview of Security and Confidentiality Protections

The California Department of Health Services (DHS), Office of AIDS (OA) is the lead agency responsible for coordinating HIV/AIDS-related programs and activities pursuant to California Health and Safety Code (HSC) Section 100119. In carrying out its statutory responsibility, OA has established measures to protect the security and confidentiality of, and restrict access to, data and information held in the HIV/AIDS surveillance system. All OA and local health department staff and their agents having any HIV/AIDS surveillance-related job duties are required to comply with OA data security and confidentiality procedures.

All HIV/AIDS case report records and any information collected in the course of surveillance-related activities that would permit the direct or indirect identification of an individual are considered confidential public health record(s), to be held in strict confidence and protected from disclosure under various provisions of state and federal law. While assuring the privacy of individuals is both a legal and ethical obligation, it is also imperative because of the potential for considerable harm ensuing from violations of confidentiality. Such adverse outcomes include stigmatization, discrimination, loss of employment, denial of insurance, eviction, and the rejection of family and friends. Moreover, wrongful disclosures give cause for legal proceedings alleging infringement of statutory confidentiality protection, discrimination, invasion of privacy, and/or intentional or negligent infliction of emotional distress. Proper safeguarding of private medical information not only fosters public trust in the surveillance system, but also serves to promote the mission of the Office of AIDS. It is the responsibility and explicit duty of all staff members who perform HIV/AIDS surveillance activities to protect the security and privacy of all case information acquired or accessed in the course

of daily work. Confidential surveillance information must not be used or disclosed for any purpose other than that which is permitted by statute, unless otherwise authorized in writing by the person who is the subject of that information.

All HIV/AIDS surveillance personnel, including information technology (IT) employees, contractors, or any other agent of the department who requires access to confidential public health records to carry out assigned duties must annually receive a security and confidentiality training and, pursuant to HSC 121022(e), must sign a Confidentiality Agreement (DHS 8689 (4/06)). The Agreement must be signed at time of employment and every twelve months thereafter. No individual shall access confidential surveillance information until the signed Confidentiality Agreement is approved and signed by the Chief of the OA HIV/AIDS Case Registry Section (OA Registry) or designee. Additionally, no staff member shall be assigned or posses any keys, passwords, codes or electronic key cards that would permit access to confidential surveillance information until such authorization has been granted and verified. The OA Registry will maintain the original signed Confidentiality Agreement on file; a copy of the document must also be retained by the local health department and the undersigned. Any breach of the Confidentiality Agreement will result in immediate disciplinary action, ranging from employee reprimand to termination of employment. Additionally, a breach of confidentiality may be subject to civil and/or criminal penalties, including fines and imprisonment, depending on the nature of the violation.

Ultimately, all staff members who are authorized to access confidential surveillance information must be knowledgeable about Office of AIDS security and confidentiality procedures. Additionally, each individual is responsible for carefully attending to security irregularities and immediately reporting suspected breaches to the appropriate authority. Any infringement of confidentiality is an actionable offense, regardless of whether the violation was inadvertent or unintentional in nature. Any suspected breach of confidentiality shall be investigated immediately and any evidence of an actual breach shall be reported to law enforcement.

2. Definitions

2.1. "Confidential public health record or records" as defined in subdivision (c) of California Health and Safety Code Section 121035 refers to any paper or electronic record maintained by the department or a local health department or agency, or its agent, that includes data or information in a manner that identifies personal information, including, but not limited to, name, social security number, address, employer, or other information that may directly or indirectly lead to the identification of the individual who is the subject of the record. This definition applies to any data in the HIV/AIDS surveillance system and any information associated with the collection, investigation, or monitoring of case information by the Office of AIDS or a local public health department that is directly or indirectly identifying in nature. In addition to paper documents and electronic files, it also includes information communicated orally, regardless of whether such information has been incorporated into the surveillance system. For the purpose of this Agreement, confidential public health records may be referred to as "confidential surveillance information" or "confidential health information."

2.2. "Disclosure" means to divulge, transfer, release or otherwise make known, in any manner or form, identifiable or confidential information about a person.

2.3. "Breach" means the unauthorized release of confidential information ensuing from a violation of established security protocol or law.

3. Responsibilities.

All staff members or contractors who are authorized to access confidential HIV/AIDS surveillance information shall:

Confidentiality Safeguards

3.1. Regard the protection of case confidentiality as a legal and ethical obligation to be upheld for the duration of their employment and thereafter.

3.2. Sign a Confidentiality Agreement, which must be approved by the Chief of the OA Registry before accessing any confidential surveillance information.

3.3. Never discuss or divulge confidential surveillance information in the presence of unauthorized persons or outside of the workplace. All conversations, telephone or otherwise, that need to identify a case using personal identifiers, such as name, will be conducted in secured areas where no unauthorized persons may overhear.

3.4. Restrict access to confidential surveillance information strictly to those persons authorized and on a need-to-know basis. Authorized staff members and contractors may only access or use confidential health information for the purpose of carrying out their assigned duties and in accordance with OA confidentiality procedures.

Physical Security

3.5. Not allow access to secured, restricted areas by unauthorized persons (e.g. maintenance crews), unless access is granted at predetermined times when surveillance staff is available for escort around the premises. Authorized staff members and contractors must not allow unauthorized persons access to any computers, databases, or file cabinets used to process or store HIV/AIDS case information.

3.6. Be responsible for securing their keys, passwords, codes, or electronic key cards that would permit access to confidential information and restricted areas.

3.7. Keep all paper documents and/or any external storage media (e.g., diskettes, CD-ROMS) containing confidential surveillance information in a locked file cabinet when not in use.

3.8. Shred all documents containing confidential case information before disposal using a commercial quality shredder with crosscutting ability.

3.9. Never leave their workstation unattended while working with confidential surveillance information (e.g. for breaks, meetings, or at the end of the work day). Confidential case information on paper documents or on computer monitors shall not be visible to any unauthorized persons. All computer printouts with personal identifiers shall be retrieved from the printer immediately upon completing a given task. Workstations shall be secured when unattended by locking computers using a password or shutting down the system and storing any paper documents or external storage media containing confidential information in a locked file cabinet.

Technical Security

3.10. Uphold the operational security procedures of the Office of AIDS in order to provide assurance of case confidentiality and to preserve data integrity. Staff shall exercise every reasonable measure to prevent the integrity of surveillance data from being compromised through damage, destruction, or by unauthorized modification. A suspected malfunction in any security software shall be promptly reported to the immediate supervisor.

3.11. Not provide electronic files containing confidential surveillance information to other computers or Local Area Network (LAN) systems outside of the secured surveillance area, or to any computers with Internet connectivity.

3.12. Encrypt any electronic surveillance data that is not in use containing names or other personal identifiers, or any potentially identifying information, using OA-approved products that meet Federal Information Processing Standards (FIPS). When no longer needed, confidential electronic data shall be permanently deleted using methods that render the data and any fragments thereof irretrievable.

Movement of Information

3.13. Never use electronic mail transmission (e-mail) or FAX to transfer case information containing names or other personal identifiers.

3.14. Adhere to the Office of AIDS procedures for the secure transport of confidential information. When transporting information between surveillance sites, all HIV/AIDS case information must be kept inside a locked briefcase that shall remain in the possession of the authorized staff member at all times.

3.15. Ensure the secure mailing of confidential information using a double envelop protocol. The encrypted data or paper documents will be placed inside the inner envelop, addressed to a particular authorized person, sealed and marked "Confidential." The outer envelope will also contain the name and address of the particular authorized person. No portion of the outer envelope, including the sender or recipient address or label, shall contain terms that could be associated with HIV or AIDS. All packages will be mailed using traceable courier services only (e.g., FedEx).

Unauthorized Disclosure

3.16. Not include any information that may be used to identify an individual case record, either directly or indirectly, in any aggregate statistical summaries released to the public.

3.17. Immediately report any suspected breach of confidentiality to their immediate supervisor.

California Health and Safety Code

For the latest version of the California Health and Safety Code Section 121025-121035 relating to HIV/AIDS confidentiality, please view the code at the following State of California website:

State of California, Health and Safety Code Section 121025-121035

CDHS Policy Letter for AIDS HARS Case Numbers

Text of "Change of Policy" letter sent December 18, 1996 to Aids Surveillance Coordinators by James N. Creeger, Chief AIDS Case Registry Section, Office of AIDS:

Change of policy for State AIDS Case Report Numbers

December 18, 1996

TO: Aids Surveillance Coordinators

SUBJECT: Change of Policy

This letter is to formally announce a change in policy. Beginning January 1, 1997, all local AIDS Surveillance offices will incorporate the State AIDS case report number on the Report of Verified Case of Tuberculosis (RVCT) form. Please collaborate with your local tuberculosis (TB) control office to facilitate the transfer of information.

We have enclosed a copy of the RVCT form. The decision to incorporate the Sate AIDS number on the RVCT form has followed extensive discussions of the possible consequences of such actions to the individuals being reported and concerns regarding the confidentiality of TB and AIDS case information. Reporting laws for both TB and AIDS, other laws governing communicable disease reporting and confidentiality statutes, and the unique features of the reporting procedures of each condition were also reviewed in making a decision on this matter. The decision was made for the following reasons:

- Human immunodeficiency virus (HIV) infection is a known risk factor for TB disease and is currently considered the most potent rick factor for progression from TB infection to TB disease. A TB diagnosis with HIV infection constitutes a diagnosis of AIDS. Of the diseases associated with HIV infection, TB is one of the few that is transmissible, treatable, and preventable.
- California law requires known and suspected TB cases be reported to local health authorities by health care providers and laboratories. A similar law requires the reporting of diagnosed AIDS cases to the local health department. The Department's Office of Legal Services has indicated it is within California HIV disclosure laws to collect the AIDS case number on the RVCT without patient consent.
- Local jurisdictions currently report to the AIDS Case Registry using AIDS case numbers without patient consent.
- The TB Control Branch maintains the level of physical security for paper and electronic records that state laws for HIV/AIDS records' confidentiality require.
- The TB Control Branch can provide technical assistance to local TB control programs to ensure security procedures and confidentality of patient records.
- The RVCT number is already required on the AIDS case report form and by incorporating the AIDS number on the RVCT, matching of cases between registries can occur with much less staff and cost involvement. A recent Centers of Disease Control and Prevention (CDC) funded study that matched cases from both registries found significant under reporting or misreporting to the AIDS Registry.
- This reporting strengthens California TB/HIV prevention and treatment efforts in medical management, public health intervention, and program planning.

Sincerely,

/s/ James N. Creeger, Chief AIDS Case Registry Section, Office of AIDS

Note: If you have any questions about inclusion of the AIDS case report number on the RVCT form please contact any one of the following:

Janice Westenhouse of the TB Control Branch at (510) 620-3055

Susan Chapman of the Office of AIDS at (916) 449-5867

Catherine Baker of the Office of AIDS at (916) 449-5869

Transfer Protocols for TB Patients Who Move

Transfer Protocols for TB Patients who Move

The topics listed below provide instructions and information for reporting patients who move during TB treatment. The topics cover patient movement between LHJs within California, moving to another state in the United States, moving to Mexico, and moving internationally.

One of the biggest challenges facing tuberculosis (TB) healthcare workers in California is keeping track of patients who move during treatment. A uniform procedure for handling "moved" patients is essential for providing continuous and complete therapy, as well as accurate TB case reporting.

The TBCB recognizes that not all "moved" patients fit a simple pattern, and that questions will continue to arise regarding specific cases. Please call the TBCB Registry if you have any questions. Active communication can minimize the number of TB cases who "fall through the cracks".

Table of Forms and Protocols for Interjurisdictional Transfer of TB Patients (2/17/04)

The following table shows the forms and protocols to use for each type of patient transfer, both domestically and internationally.

Types of patients (click type for definition): Class 3, Class 5, LTBI, Contact, Source Case investigation, Class B1/B2 (see **Glossary** for definitions of classes).

Type of Patient	Form	Protocol	Comments	To TBCB
Other California Local Health Jurisdiction (TB patient transferring from *referring* LHJ to *destination* LHJ within California)				
TB Class 3 and 5 **LTBI** **Contact** **Source case investigation**	NTCA Interjurisdictional Notification and Follow-up	**NTCA Interjurisdictional TB Notification**	Required for cases, suspects, Class B1/B2; optional for others.	**RVCT Follow-up 2** (*cases* only)
B1/B2 immigrant/refugee	NTCA Interjurisdictional Notification and Follow-up	**B-Notification**	All referrals within California are made directly to the destination jurisdiction.	
In United States (TB patient transferring within the United States)				

Type of Patient	Form	Protocol	Comments	To TBCB
TB Class 3 and 5 **LTBI** **Contact** **Source case investigation**	NTCA Interjurisdictional Notification and Follow-up	**NTCA Interjurisdictional TB Notification**	Required for cases, suspects, Class B1/B2; optional for others. Referrals of cases, suspects, LTBIs, contacts are made directly to the destination state.	**RVCT Follow-up 2** (*cases* only)
B1/B2 immigrant/refugee	NTCA Interjurisdictional Notification and Follow-up	**A/B-Notification**	Referrals of persons with B-notifications are made through TBCB.	Route NTCA referral, CDC 75.17 Class B form and medical records through TBCB
Mexico (TB patient transfering between the United States and Mexico)				
TB Class 3 and 5 **Contact**	Binational Notification	**CureTB**	Contact: (619) 542-4013	**RVCT Follow-up 2** (*cases* only)
International (excluding Mexico) (TB patient transferring between the United States and other countries)				
TB Class 3 and 5	CDC International TB Notification *and/or* TB-Net	**CDC International Notification of TB Cases *and/or* TB-Net**	TB-Net requires patient consent.	**RVCT Follow-up 2 (*cases* only)**
International - U.S. Immigration and Customs Enforcement (TB patients who may be in ICE custody)				
Any type of TB patient or contact that may be in ICE custody	No form	**Recommended procedures for establishing continuity of TB therapy for patients believed to be in the custody of U.S.ICE**	None	**RVCT Follow-up 2 (*cases* only)**

CDC International Notification of Tuberculosis Cases

Centers for Disease Control and Prevention, Division of Tuberculosis Elimination

International Notification of Tuberculosis Cases (December 21, 2000)

Completion of therapy among TB patients is one of the critical elements of TB control. Some patients under treatment for active TB disease in the United States move to another country before completing treatment. But, TB does not stop at international borders.

In order to assist in the completion of their treatment, the CDC has developed a process for International Notification of TB cases to provide important information to TB control program personnel in the country of the patient's destination. Through this process the personnel in the TB control program are informed of the circumstances and encouraged to complete treatment. This information should be given to the patient as well. In addition, these patients should be advised to seek medical care and educated as to the importance of completing treatment in their new location.

Resources and contact information

The information for the CDC process, including the form and the international addresses for notification can be found on the following website:

http://www.cdc.gov/nchstp/tb/pubs/international/international.htm

CureTB - Transfers Between U.S. and Mexico

CureTB Binational Tuberculosis Referral Program

About the CureTB Binational Tuberculosis Referral Program

CureTB is a referral program for tuberculosis patients and their contacts moving between the United States and Mexico. Services are available to patients and health care providers throughout the United States and Mexico. This program provides direct guidance for patients and facilitates the exchange of information between health care providers in the U.S. and Mexico. CureTB is based in the TB Control Department of the San Diego County Health and Human Services Agency.

Goal:

The primary goal of CureTB is to facilitate the continuity of tuberculosis care for active cases and their contacts traveling between and/or living in the U.S. and Mexico.

Services:

- Referral for continuity of care of patients with active or suspected TB who are moving between the United States and Mexico.
- Referral for continuity of care of contacts to an active case who move between the United States and Mexico.
- Referral to screen contacts living in Mexico who have been exposed to a confirmed infectious case living in the U.S.
- Referral to screen a potential source case across the border when there is reasonable and significant suspicion of active disease in that person.
- Requests for a patient's clinical history if sufficient information is available to locate the health care provider. *

Note: For patients coming from Mexico, available information may be limited to clinical evaluation, sputum smear, x-ray results and treatment history.

Important: Treatment of LTBI for TB skin test (TST) positive patients without a history of contact with an active TB case (i.e. as a result of routine TST screening) is not a priority in Mexico. The referral of these patients will not be processed by CureTB.

Referral process:

Referral of tuberculosis patients (cases or suspects) from the United States to Mexico:

1. Health care provider identifies a patient planning to travel or move to Mexico.
2. Health care provider informs the patient about CureTB services and provides the patient with a pocket card with the 1-800 CureTB telephone number.
3. Provider sends a completed referral form to CureTB or phones with information.
4. The referral is assigned to a CureTB case manager, translated into Spanish and faxed to the Mexican National TB Program and to the State or local health department or health jurisdiction named by the patient as his/her destination in Mexico. The receiving jurisdictions will also be contacted by phone and notified of the referral.
5. The CureTB case manager will call the referring jurisdictions to inform them of the referral's initial disposition. The name and telephone number of the CureTB case manager will be given to the referring jurisdiction as the lead contact person on the referral. The referring jurisdiction is encouraged to call the CureTB case manager if additional information relevant to the patient's status is available (i.e. clinical or locating information, culture and sensitivity results, contacts for investigation, etc.)
6. The CureTB case manager will contact the patients by telephone whenever possible to encourage them to seek treatment from the health care institutions in Mexico, and to provide education about TB infection and disease.

Referral of contacts from the United States to Mexico:

1. Contacts to an active case who are under treatment for latent TB infection may be referred for continuity of care when they travel or move to Mexico.
2. Referrals to screen contacts living in Mexico will be processed only if there is a history of exposure to a confirmed infectious case living in the United States.
3. Contact referrals must include information on the source case.

Referral for source case finding:

Referrals to screen a potential source case will be processed if:

1. There is reasonable and significant suspicion of active disease in a specific person living in Mexico.
2. Sufficient information is provided to locate the potential source case.

Requests for a patient's clinical history:

1. Sufficient information to locate the patient's health care provider is necessary.
2. The information available from Mexico may be limited to clinical evaluation, sputum smear and x-ray results and treatment history. Cultures are not routinely performed in Mexico.

Referral status reports:

Health departments will be notified of the status of referred patients according to the following guidelines:

A. Cases: Status reports for all verified tuberculosis cases will be sent to the referring jurisdictions at intervals of six months from the date the referral was received by the CureTB Program. After notification of initial disposition, subsequent status reports will be sent sooner than six months only if relevant information is available.

B. Suspects: The classification of suspects will be updated within a period of three months from the date the referral was received by the CureTB Program. After notification of initial disposition, additional reports, if required, will be sent at intervals of six months if the patient is reclassified as a verified case, and sooner than six months only if relevant information is available.

C. Other referrals: Referring jurisdictions will be given a preliminary update, upon request, within the first two weeks from the date the referral was received by the CureTB Program, but no sooner than three working days. This information will be verbal.

Notification of referral outcome:

The CureTB case manager will document the final outcome for all referrals. A written outcome report will be provided to the referring jurisdictions as soon as there is sufficient information to consider the outcome as final. Outcome reports will be sent to the originating health department.

Binational Notification Form Instructions for Completion

To obtain a copy of the CureTB Binational Notification form, see TB Surveillance report forms – viewing and printing in the Welcome section of this document.

Instructions for completing the CureTB Binational Notification form:

1. **Referring jurisdiction**: Complete location, name, phone and fax numbers and date referral initiated.
2. **Patient category**: If the patient's diagnosis has been verified, include information on the state reporting to CDC and the RVCT number; if the patient is being referred from ICE facilities (formerly INS), include the A number. For other referrals including HIV/AIDS patients, mark as appropriate.
3. **Patient's Name**: Hispanic individuals often use both paternal and maternal last names in that order. When completing patient's name it is important to indicate both last names, specifying which is the paternal, if this information is available.
4. **New Address**: Be specific and detailed regarding the patient's address. Include the Fraccionamiento or Colonia (neighborhood), as well as the street address, town or city, state, zip code (called postal code in Mexico) and telephone number (including the area code), when available. Referrals with insufficient information to locate the patient will not be processed.

5. **Emergency contact information**: Provide information on contacts (family members or friends) in the U.S. and/or Mexico who may help locate the patient.
6. **Clinical Information**: Complete as fully as possible, include all laboratory and X-ray reports with the referral. If cultures and susceptibilities are not final, please forward this information when final. Clarify susceptibility results and dates of specimen collection. Include as much information on treatment as possible.

Resources and contact information

Information: Also see: A memorandum of Understanding between the Migrant Clinicians Network (TB NET) and the San Diego County TB Control Program (CureTB)

CureTB toll-free telephone number for patients:

The CureTB Program has a toll-free telephone number for the purpose of eliminating barriers to communication. Patients are highly encouraged to call for information about tuberculosis, continuing tuberculosis care or how to access medical services in the United States or Mexico.

To access the toll-free line from anywhere in the United States, the patient should dial **1-800-789-1751**

To access the toll-free line from anywhere in Mexico, the patient should dial **001-800-789-1751**

CureTB contact information:

Website: http://www2.sdcounty.ca.gov/hhsa/ServiceDetails.asp

Main Program Number: Phone (619) 542-4013 FAX (619) 692-8020

Office hours: 8:00 AM to 5:00 PM Pacific Standard Time. All phone lines have voice mail capability.

Mailing Address:

CureTB Binational Tuberculosis Referral Program
3851 Rosecrans St.
P.O. Box 85222, MS P511D
San Diego, CA 92186-5222

CureTB and TBNet Understanding

Memorandum of Understanding between the Migrant Clinicians Network (TB NET) and the San Diego County TB Control Program (CureTB)

1. For TB cases referred from Mexico to the US, they will be referred via CureTB to providers in the US (using the 1-800 number from CureTB) to ensure continuity of care;
2. For migrant populations moving within the United States, TB NET will retain operations as currently in place;
3. For TB cases referred to Mexico from the US, they will be referred through CureTB to health providers in Mexico, unless;

    a) TB NET has followed the patient for two months or more of treatment in the US, direct referral from TB NET to Mexico should occur,

    b) TB NET will refer patients originating in Texas or New Mexico to Mexico;
4. With respect to INS-related TB management, TB NET and CureTB will continue the current system of geographic division of labor;
5. TB NET will refer patients to countries other than Mexico;
6. The program (CureTB, TB NET) performing the referral is responsible for maintaining the data on each patient and providing feedback/ treatment outcome data to the agency/ program requesting the referral;
7. TB NET and CureTB will be the lead US referral programs and will collect common data elements and will share data annually at technical meetings. Binational Projects/ Border TB Programs will be invited to participate in these meetings;
8. TB NET and CureTB agree to work with Mexico and key partners in establishing and evaluating a bilateral TB referral program.

_____	_____
Ed Zuroweste, MD;	**Kathleen Moser, MD;**
Medical Director,	**Director,**
Migrant Clinicians Network, Inc.	**San Diego County TB Control Program**

ICE - U.S. Immigration and Customs Enforcement

This topic describes notifications of confirmed and suspected active TB patients in the custody of U.S. Immigration and Customs Enforcement.

Tuberculosis Patients in Custody of the United States Immigration and Customs Enforcement (ICE)

> **Note:** On March 1, 2003, the Immigration and Naturalization Service (INS) became part of the Department of Homeland Security (DHS) and is no longer part of the Department of Justice. The enforcement arm of what was INS (under which the INS detention and removal operations fell) will no longer be called "The Immigration and Naturalization Service." It now falls under the Department of Homeland Security, Directorate of Border and Transportation Security, Bureau of Immigration and Customs Enforcement. For additional information on the Department of Homeland Security, please see http://www.dhs.gov/dhspublic/.

Background

Approximately 100-150 TB cases are identified annually among ICE (formerly INS) detainees in the ICE service processing centers (SPCs) and contract detention facilities. Approximately 30% of TB cases in an ICE detention center in FY 2001 and 2002 was released back into the U.S.

Approximately one third of ICE detainees is held in facilities with on-site Division of Immigration Health Services (DIHS) health care staff. These facilities often make referrals to CureTB or TB Net for post-detention continuity of care arrangements.

The other two thirds of ICE detainees are held in approximately 400 contract facilities. For patients in ICE beds in local jails or prisons, there is currently no system for notification of DIHS of TB cases or planned removals. DIHS has Managed Care Coordinators who coordinate care provided in the community for ICE detainees held in contract facilities. The Managed Care Coordinators are activated when there is a need for health services in the community, or when a financial claim is generated, such as for lab work performed outside the facility. Thus, if health care is provided on site, or if the detainee does not need care from a community provider, these coordinators would have no prior knowledge of a patient. However, contacts at DIHS (see attached protocol) or the DIHS Managed Care Coordinators (202-514-3339) can help locate a patient if they are notified by the TB Controllers.

The Advisory Council for the Elimination of TB is currently working with the Centers for Disease Control and Prevention (CDC), ICE, and DIHS to improve continuity of care for detained patients.

Notification of TB patients in the custody of the ICE

If you are following a patient who is placed in ICE custody or determine that a jail or prison inmate with known/suspected TB is an ICE detainee, please notify the appropriate contacts at DIHS (see attached contact information).

The purpose of your notification to DIHS is two-fold:

1. DIHS may help you find patients in the ICE system,
2. You can help DIHS by ensuring that DIHS knows about cases TB controllers are following in the community who are subsequently placed in INS custody, or if TB controllers determine that a jail or prison inmate with known/suspected TB is an ICE detainee.

California TB programs should also notify CureTB of Mexican-born TB patients in ICE custody. Early notification to the referral programs allows time to make continuity arrangements before the patients are released.

Recommended procedures

Recommended procedures for establishing continuity of TB therapy for patients believed to be in the custody of U.S. Immigration and Customs Enforcement:

1. Ascertain whether the patient is officially in the custody of U.S. Immigration and Customs Enforcement (ICE)

2. If it is not known whether the patient is currently in ICE custody, communicate with the contacts listed below at Immigration Health Services, who will ascertain custody status, and detention location if the patient is in official custody

3. For patients who are illegal aliens, in official ICE custody, held in a detention or correctional facility that does not have an Immigration Health Services medical facility on site:

3.1. Please send the following information to the contacts listed under Resources and contact information:

3.1.1. Patient's Alien number ("A number"); try to ascertain from detention facility (this will be an eight-or nine-digit number)

3.1.2. Patient's country of origin; try to ascertain from detention facility

3.1.3. Identifying information [A number, name, alias (if applicable), birth date]

3.1.4. Surveillance information (lab reports are not required)

3.1.5. Cure TB or TB Net enrollment forms (if already enrolled)

3.1.6. International TB Notification forms (if already completed)

3.1.7. Name, address, country, and telephone number of a contact in country of origin

3.1.8. Name, address, and telephone number of a contact in the U.S.

4. For patients who are illegal aliens, in ICE custody, held in an ICE detention facility or ICE contract detention facility that has an Immigration Health Services medical facility on site:

4.1. Communicate with/share case information with the Immigration Health Services health care providers at the detention facility medical clinic

4.2. It is not necessary to notify Drs. Schneider or Newman of TB cases adequately coordinated with Immigration Health Services medical personnel at the facility

4.3. Contact Drs. Schneider or Newman with any additional concerns

5. Immigration Health Services personnel do not have authority to facilitate continuity of care for patients who are not officially in ICE custody

6. Presently it is difficult to track TB patients who are not currently in ICE custody, even if they may be transferred to ICE custody in the future.

Resources and contact information

Contact at Immigration Health Services:

Dr. Diana Schneider, Senior Epidemiologist

Email: Diana.Schneider@dhs.gov

Phone: (202) 732-0070

Fax: (202) 732-0095

NTCA - Local and U.S. Interjurisdictional Notification

Interjurisdictional Tuberculosis (TB) Notification - National Tuberculosis Controllers Association Recommendations (NTCA March 2002)

I. Purpose:

The movement of TB patients from one jurisdiction to another is a unique challenge to public health providers and requires that health departments share information promptly in order to maximize the likelihood of continuity of care. To understand the scope and causes of lack of continuity, it is also incumbent on health departments to take responsibility for analyzing outcomes of TB patients that move. The Interjurisdictional TB Notification system will facilitate and standardize interstate communication to enhance continuity and completeness of care. It should also improve outcome evaluation of verified cases. These forms should replace other interstate notification forms currently in use. States may choose to use other forms for internal (intrastate) notification.

Note: In most instances, TB notifications will be exchanged between state health departments. However, in some states these notifications may be best sent directly to local jurisdictions. For guidance on how to proceed with individual states, contact the state-level Interjurisdictional Contact as indicated in the NTCA directory.

II. Definitions:

A. Referring jurisdiction: The jurisdiction that initiates the interjurisdictional notification. For most Class 3 and Class 5 referrals, the referring jurisdiction will be the same as the reporting jurisdiction.

B. Reporting jurisdiction: The jurisdiction that reports a Class 3 patient to the Centers for Disease Control and Prevention (CDC) and, therefore, counts the case in their jurisdiction.

C. Receiving jurisdiction: The jurisdiction that receives the interjurisdictional notification.

D. Class 2: Latent TB infection, no evidence of current disease

E. Class 3: Verified active TB disease; in the US these would be cases that meet the CDC verification definition.

F. Class 5: A suspected case of active TB disease.

G. RVCT: The Report of Verified Case of TB is the national form used to report verified cases to the CDC.

H. F/U 2: The Follow-up 2 is the national form used to report outcomes of verified cases to the CDC.

III. Forms:

Note: To obtain a copy of the NTCA forms, see TB Surveillance report forms – viewing and printing in the Welcome section of this document.

A. Interjurisdictional TB Notification: Provides a standard array of information to be transmitted to new jurisdictions for Class 3 and 5 patients, contacts, and persons with latent TB infection (LTBI), and source case findings.

B. Interjurisdictional TB Notification Follow-up: Provides a standard array of follow-up information to be transmitted back to referring jurisdictions.

IV. When to send an Interjurisdictional TB Notification:

Notifications should be sent by all jurisdictions for Class 3 and 5 cases. Notification is optional for contacts, LTBI convertors, LTBI reactors, and source case findings. In addition, notifications should not be sent for contacts, LTBI convertors, LTBI reactors, and source case findings unless reasonable locating information is available, usually consisting of at least a street address or phone number.

A. Class 3 and 5 Patients: An Interjurisdictional TB Notification should always be initiated when a Class 3 or 5 patient will be moving out of the area for 30 days or more. Notification may be initiated for patients with shorter planned stays or less than 30 days of treatment remaining at the time of their move, at the discretion of the referring jurisdiction. For example, if a patient must continue DOT after they move, a notification should be initiated.

B. Contacts: For close contacts to AFB smear positive or smear negative Class 3 pulmonary cases. If there are multiple contact to the same case, they should have individual notifications sent.

C. LTBI Convertors: For documented convertors who have initiated treatment and who will be moving out of the area for 30 days or more. The results and dates of the last negative skin test and the first positive skin test must be entered into the Contact/LTBI section to provide information on when the skin test conversion occurred.

D. LTBI Reactors: For Class 2 and 4 patients who have initiated treatment and who will be moving out of the area for 30 days or more. For Class 2 patients, include specific risk factors for disease progression to assist receiving jurisdictions prioritize follow-up.

E. Source Case Finding: For investigation of close associates to a Class 3 index case when that index case has a clinical presentation consistent with recently acquired disease (e.g. children who are <3 years of age). Notifications should not routinely be sent to perform source case finding for a child with LTBI.

Instructions for Interjurisdictional TB Notification form:

Indicate when key information is unknown or pending, do not just leave blank.

A. Referring Jurisdiction Information: Complete all information to provide specific contact information for the receiving jurisdiction.

B. Referral Category: Specify the type of patient referral. For verified cases, supply the RVCT number and State that reported to the CDC. This will allow the receiving jurisdiction to ensure the F/U 2 is sent to the reporting jurisdiction. Attach the RVCT form whenever possible. For classified immigrants attach pertinent overseas forms when available.

C. Patient Information: Complete all information. If some elements are unknown, indicate this in the space provided. The Emergency Contact should be a relative or associate who is likely to have locating information about the referred patient.

D. Clinical Information: When some or all of the laboratory information is pending at the time of referral, the referring jurisdiction should indicate this and update the information when available. To ensure rapid transfer of information, updates should be accomplished by faxing an updated Notification form or by calling the receiving jurisdiction. The TST information in this section should be used for cases/suspects only.

Attach copies of laboratory and X-ray information whenever possible. The Other section should include additional types of tests including CT scans, NAAT tests – attach copies of the reports whenever possible.

E. Contact/LTBI Information: This section should be used for contacts, convertors, and reactors. The TB skin test #1 and #2 should be completed for all convertor referrals and for other referrals when appropriate. For contact referrals, exposure information should be completed to enhance appropriate investigation by the receiving jurisdiction.

F. Medications: Complete as indicated. Supply adherence information that may be of importance to the receiving jurisdiction for appropriate patient management.

G. Follow-up: All Class 3 and 5 referrals require an Interjurisdictional TB Notification Follow-up to be sent by the receiving jurisdiction. For other referral categories, the referring area should indicate if the Follow-up form is requested. Note that the ultimate decision to provide follow-up for contacts, convertors, and reactors is at the discretion of the receiving jurisdiction.

V. When to send the Interjurisdictional TB Notification Follow-up:

A. 30-day status: At 30 days after notification was received, a status report should be sent to the referring jurisdiction. In instances when the patient is not located within 30 days, “lost” will be considered to represent the final disposition. If the patient is subsequently located, an update should be sent to the referring jurisdiction using the Follow-up form. Some jurisdictions may not perform follow-up on contact, LTBI, or source case finding referrals. In these cases, the final status of “no follow-up performed” should be indicated. Follow-up should be performed and sent to referring jurisdictions for all Class 3 patients.

B. Interim status: May send if an interim update in status is appropriate.

C. Final status: When a final status is known.

Instructions for Interjurisdictional TB Follow-up form:

A. Date Notification Received: Receiving jurisdiction should indicate the date the Interjurisdictional Referral was received.

B. Status:

30 days: At 30 days after notification was received, a status report should be sent to the referring jurisdiction. In instances when the patient is not located within 30 days, “lost” will be considered to represent the final disposition. If the patient is subsequently located, an update should be sent to the referring jurisdiction using the Follow-up form.

Interim: Should use whenever updated information needs to be sent to the referring jurisdiction.

Final: To be used at the time a final status is known.

C. Return follow-up form to: The receiving jurisdiction should complete this information using the contact information provided on the original Interjurisdictional Referral form (or may use the Interjurisdictional Contact information from the NTCA Directory).

D. Patient information: Complete as indicated.

E. Case: Final outcome in the receiving jurisdiction will be indicated. The F/U 2 should be sent to the reporting jurisdiction. The original reporting area will be responsible for getting F/U 2 results to the CDC. (See RVCT Moves - Follow-Up 2 Reporting For Tuberculosis Patients that Move for specific instructions about using the Follow-Up 2 report for move notifications.)

F. Suspect: The receiving jurisdiction will indicate whether the Class 5 case was verified, and if so, the method of verification. In some cases, the referring jurisdiction may still be the appropriate jurisdiction to report the case. If so, the receiving jurisdiction should also provide a final follow-up status and F/U 2 to the reporting jurisdiction (see "E. Case" above). This section can also be used to provide follow-up information for individuals investigated as part of a source case finding.

G. Contact: Some jurisdictions may not provide follow-up on all contact referrals and should indicate, “No follow-up performed” on the 30-day status report. If follow-up is performed, indicate the final outcome. Whenever possible, the receiving jurisdiction should attach contact follow-up information including screening dates and results, as well as treatment dates and outcome. This will assist the referring area in completing contact information required by the CDC.

H. LTBI: Some jurisdictions may not provide follow-up on all LTBI referrals and should indicate, “No follow-up performed” on the 30-day status report. If follow-up is performed and the patient is located, indicate the outcome. This section can also be used to provide follow-up information for convertors.

Resources and contact information

National Tuberculosis Controllers Association: http://www.ntca-tb.org/index1.htm

TBNet International Tracking and Referral

Using the TBNet Referral Service

Purpose:

TBNet provides a patient tracking and referral service for mobile persons diagnosed with tuberculosis disease or latent TB infection in order to improve continuity of care and completion of treatment no matter where the patient moves.

How it works:

- Mobile patients are enrolled (with consent) into TBNet by the health care provider. TBNet collects and stores patient's diagnostic, treatment, and locating information.
- Patients are provided with a health card that has a toll-free number for them to call TBNet if they move and need a referral to a health care facility.
- If the patient moves, the health department uses its normal inter-jurisdictional referral process to notify the receiving jurisdiction and alerts TBNet. If the patient is lost to follow-up, the health department or provider can also alert TBNet.

Who can be referred:

- Active cases moving within the US,
- Active cases moving outside the US, excluding Mexico (contact Cure TB for MX referrals),
- Individuals with LTBI moving within the US, or
- High-risk individuals with LTBI moving to Mexico.

How to make a referral:

- Contact TBNet to obtain the manual with instructions and enrollment forms (also can be downloaded from the internet).
- Enroll mobile patients in TBNet early on in the evaluation or treatment process, even if they do not plan on moving before completing treatment. Patient consent must be obtained in order to enroll.
- Notify TBNet if patient moves.
- TBNet will notify or make referrals to appropriate clinic(s) and report back final patient outcome to originating health department.

Resources and contact information

For further information or to obtain a TBNet manual:

Phone number: 1-800-825-8205

Website: http://www.migrantclinician.org

RVCT Follow-Up 2 Reporting For Tuberculosis Patients that Move

RVCT and Case Completion (Follow-Up 2) Reporting For Tuberculosis Patients that Move (02/27/2003)

I. Referring Jurisdiction Responsibilities

You are a referring jurisdiction if the TB case was counted (reported to the TBCB) by your jurisdiction. When a patient moves out of your jurisdiction before completing therapy, you have several responsibilities to ensure continuity of care for this patient, including notifying the destination jurisdiction and forwarding the relevant medical records to them. It is also your responsibility to notify the TBCB Registry when a patient moves, using the following steps.

1. Complete an RVCT and Initial Drug Susceptibility Report (Follow-up 1) and submit them to TBCB, if this has not already been done.
2. Complete the Case Completion Report (Follow-up 2). Question #37, "Reason Therapy Stopped" should be designated as "Moved". Also indicate the 2-digit numeric code for destination county in the space provided next to the "Moved" box. If the patient is moving out of California or the U.S., enter the entire state or country name. In the "Comments" section at the bottom of the form, enter the patient's new address, including street, city, county and phone number. This information must be included for the patient to be considered "moved". Submit the Follow-up 2 Report to the TBCB within 2 weeks of a patient's move.

   Note to TIMS users: If you transmit your data to TBCB via TIMS you must also enter the 2-digit numeric code of the destination county into the User Defined Variable "Destination Jurisdiction" which is attached to the Follow-Up 2 screen (see attached list of codes). If the patient is moving to another jurisdiction in California, the two-digit numeric code for the destination LHJ must be entered into the FU-2 User Field "Destination Jurisdiction". If the patient is moving out of California or the U.S., write out the entire state or country name. Do not write out the full name of any county - use only the numeric code.
3. Notify the health department of the destination jurisdiction immediately upon learning of a patient's impending departure from your jurisdiction. Use the NTCA Interjurisdictional Tuberculosis Notification form for this purpose. A copy of the RVCT, FU-1 and FU-2 and pertinent medical records must also be forwarded. To ensure that each case is only counted once, let the next jurisdiction know that you have reported this case to the TBCB. It is recommended that you contact the destination jurisdiction by telephone, as well as forwarding the records by mail. Record the date notification was made in the "Comments" section at the bottom of the FU-2.
4. When the patient has completed therapy (or met another treatment outcome) in the destination jurisdiction, the TBCB will forward a hardcopy of the FU-2 with the updated "Reason Therapy Stopped" to you. This updated FU-2 must be entered into TIMS and transmitted to the TBCB. If your jurisdiction uses paper-based RVCT reporting, the updated FU-2 will be entered by the TBCB Registry, and you will receive a copy for your records.

   Note to TIMS users: Follow-up 2 Reports on patients who are counted by your jurisdiction, but who complete therapy (or other final outcome) in another jurisdiction can only be entered into the TIMS system in your jurisdiction. The data entry cannot be done at another jurisdiction, or at the TBCB. When paper FU-2 reports on these cases are received at TBCB, a copy will be forwarded to you for data entry. You will need to locate this case in your TIMS database, and enter the new FU-2 in the "Case Completion Report" window. You will be revising (writing over) your original FU-2, which will update your database (and hence, the TB registries of the TBCB and the Centers for Disease Control and Prevention). The TBCB will retain of record of the move in a separate database.
5. If the patient cannot been located by the destination jurisdiction, you will be asked by the TBCB Registry for any further information on the patient's whereabouts. If/when it is determined that the patient cannot be located, the TBCB will ask you to enter an updated FU-2 with "Lost" as the "Reason Therapy Stopped" (Question 37).

II. Destination Jurisdiction Responsibilities

You are a destination jurisdiction if you receive a TB patient that has already been reported by another jurisdiction. The previous jurisdiction should notify you that the patient is moving into your

jurisdiction to continue therapy under your supervision. The responsibilities of the destination jurisdiction include the following.

1. Use the NTCA Interjurisdictional TB Follow-up form to notify the referring jurisdiction when you locate the patient. Refer to Tab 5 of the Tuberculosis Registry Guidelines for instructions on using the NTCA protocol and forms.
2. With each quarter's packet of RVCT Quality Control (QC) line listings from the TBCB Registry*, the destination jurisdiction will receive a list of patients who have "Reportedly Moved Into Your Jurisdiction". This QC listing must be faxed back to the Registry within 2 weeks, noting the status of each patient who was reported to have moved into your jurisdiction.

   For example:

   - If the patient has already completed therapy, note that on the QC line listing, and submit a hardcopy FU-2 with a response of "Completed Therapy" to Question 37.
   - If the patient is currently under care in your jurisdiction, note "still on treatment" on the QC line listing. Submit an updated hardcopy FU-2 when the patient does complete therapy.
   - If the patient has moved again, note the new destination on the QC line listing and submit a hardcopy FU-2 with "Moved" in Question 37.
   - If, after "reasonable attempts" to locate the patient (see "Tuberculosis Patient Lost to Follow-up: TBCB Field Investigation Assistance") you have not been successful, note "patient not located" on the QC line listing and fax it to the TBCB Registry. Also, the TBCB Patient Locating Service is available to assist local jurisdictions with locating lost patients. (See attached flier "TB Patient Locating Service".)
3. When completing a FU-2 on a patient reported by another jurisdiction, provide information only on events that occurred in your jurisdiction. For example, "Weeks on DOT" should indicate the number of weeks the patient received directly observed therapy in your jurisdiction. Complete the "Sputum Culture Conversion Dates" if the patient's sputum cultures become negative in your county. In this case, the "Date Specimen Collected on Initial Positive Sputum Culture" may have to be obtained from the originating county. All other information on the FU-2 should be specific to your jurisdiction.

Note to TIMS users: Follow-up 2 reports on TB patients who have been counted by another jurisdiction, but complete therapy (or other outcome) in your county cannot be entered into your TIMS database. Simply complete a paper FU-2 as outlined above and submit it to TBCB.

III. Correctional Facility Patients who are Transferred, Paroled or Released

RVCT reporting requirements for this important group of patients are identical to those for non-correctional patients. If a resident of a correctional facility has been counted as a case of TB in your jurisdiction see I. Referring Jurisdiction Responsibilities, above. If correctional TB patient who has already been reported by another jurisdiction is transferred, released or paroled into your LHJ before therapy is completed, see II. Destination Jurisdiction Responsibilities, above. The designated Correctional Liaison of each LHJ should be able to assist in identifying the location and treatment status for each correctional case of TB.

For further information on the roles and responsibilities of LHJs and correctional facilities in ensuring continuity of care for TB patients in correctional facilities, please refer to Resources.

IV. Patients Moving to Another State

If you are a referring jurisdiction for a patient moving to another state, proceed as outlined in "Referring Jurisdiction Responsibilities" above. On a quarterly basis, the TBCB Registry will contact the destination state (as identified by the FU-2) asking for an update on the patient's status. If the patient has completed treatment in that state, they will be asked to submit a hardcopy FU-2 to the TBCB Registry, which will be forwarded to the referring jurisdiction for entry into TIMS. The TBCB Registry will enter the FU-2 data for jurisdictions with paper-based reporting. The outcome of "Completed Therapy" will replace the previous outcome of "Moved".

Some jurisdictions may prefer to contact destination states directly regarding the status of their moved patients rather than waiting for information through the TBCB. Also, some states may submit treatment completion information on your moved patients directly to your jurisdiction. Any treatment outcome information received through this means should be entered into TIMS after notifying the TBCB Registry.

V. Patients Moving Into Your Jurisdiction from Another State

If your jurisdiction receives notice of a patient moving into your jurisdiction from another state, it is your responsibility to notify the referring state when you have located the patient, and again when the patient completes therapy. Please refer to the NTCA Interjurisdictional Tuberculosis Notification protocol.

Closing TB Cases

RVCT Report - Administrative Closure of TB Cases

This **Administrative Closure of TB Cases** topic provides important instructions and information that are in addition to the primary RVCT form completion instructions. You will need to consider these instructions when you fill out the RVCT and Follow Up Report forms, whether you enter them online, submit them via a data-exchange protocol, or fax them to the CDHS, TBCB Registry.

 **California state**: The information on Administrative closure of TB cases in this topic applies to the State of California and is a protocol issued by the California Department of Health Services.

Background

It is recognized that some physicians (often those outside the public health department) extend treatment beyond what would normally be considered an adequate or "recommended" treatment regimen. Reasons for extending treatment have not been well documented but may include lack of awareness of the recommended TB drug regimen or choosing to err on the side of caution to ensure patient cure. In these cases, some local health departments have chosen not to follow-up on these patients beyond the period of recommended duration of treatment. Depending on the health department, this may mean termination of DOT or other case management services, and closure of the patient's file.

These situations raise the question of whether these cases should be reported as "administratively closed" on the Report of Verified Case of Tuberculosis (RVCT), Follow-up 2. The two variables of interest are "Date Therapy Stopped" (Q 36) and "Reason Therapy Stopped" (Q 37). Following discussions with the Centers for Disease Control and Prevention (CDC), California Department of Health Services has issued this protocol on administrative closure of TB cases.

Policy on Administrative Closure of TB Cases

Local health jurisdictions (LHJ) are permitted to close a case of tuberculosis administratively. The date of administrative closure is at the discretion of the local health department. However, it is recommended that the patient will have completed an ATS/CDC recommended TB regimen with documentation of clinical and bacteriological response to treatment. Local health departments may also choose to discontinue directly observed therapy (DOT) or other case management services at that time.

Reporting of Administrative Closure

While acknowledging that administrative closure of a TB case is an acceptable public health practice, it should be distinguished from treatment discontinuation. For surveillance purposes, the LHJ remains responsible for documenting the date therapy was actually discontinued. For national and statewide TB surveillance data to be useful, it is mandatory that the data be collected consistently and according to published RVCT guidelines in all programs. Exceptions to this are patients who may be maintained on lifelong treatment due to multi-drug resistant TB. RVCT reporting protocols for administratively closed patients and for patients on lifelong treatment are as stated below.

RVCT Reporting for Administratively Closed Patients

A Follow-up 2 form should not be submitted on administrative closures until treatment has ceased. Local health departments are responsible for identifying the "Date that the patient last ingested medication", as per the RVCT Form Completion Instructions. This is the date that should be used for "Date Therapy Stopped" (Q 36). Do not use the date that the case was administratively closed by the local health department if the patient continues on anti-TB treatment. At the time of treatment discontinuation "Reason Therapy Stopped" (Q 37) will usually be "Completed therapy".

RVCT Reporting for Patients on Lifelong TB Treatment

When it is determined that a patient will continue on TB medication for their entire life, submit a Follow-up 2 form to the state. In this case "Date Therapy Stopped" may be the date that the LHJ closes the case administratively. "Reason Therapy Stopped" should be marked "Other". In the Comments field state that the patient will continue on lifelong therapy.

Comments

The RVCT Form Completion Instructions clearly define the “Date Therapy Stopped” as being the last date of medication ingestion. Valid data in this field are necessary to accurately evaluate the length of patient treatment. Jurisdictions with a disproportionate number of cases completing therapy in more than 12 months may want to use that opportunity to identify the reasons for treatment beyond the recommended regimen, and take action as indicated.

RVCT Report - Identification of Not TB Cases

This **Identification of Not TB Cases** topic provides important instructions and information that are in addition to the primary RVCT form completion instructions. You will need to consider these instructions when you fill out the RVCT and Follow Up Report forms, whether you enter them online, submit them via a data-exchange protocol, or fax them to the CDHS, TBCB Registry.

 **California state**: The information on identification of "Not TB" cases in this topic applies to the State of California and is a protocol issued by the California Department of Health Services.

Background

Occasionally a case of tuberculosis that has been submitted to the Tuberculosis Control Case *Registry* is discovered to have been reported in error. In other words, the reported case is not actually a case of tuberculosis. This can happen for a variety of reasons such as laboratory cross-contamination, or a change in the diagnosis. These cases must be deleted from our database if we are to maintain an accurate record of tuberculosis cases in California. However, we also need an efficient tracking mechanism for these cases if we are to determine the sources and magnitude of this problem. The following protocol will enable the Registry to meet these objectives.

Laboratory Cross-Contamination

If it is determined that a case has been submitted to the Registry but is “Not TB” due to lab contamination, please submit a new Follow-up 2 Report. Under "Reason Therapy Stopped” (Q 37) select “Not TB.” In the Comments field write “Case resulted from laboratory cross-contamination.”

Other “Not-TB”

If it is determined that a case has been submitted to the Registry but is “Not TB” due to a reason other than lab contamination, please submit a a new Follow-up 2 Report. Under "Reason Therapy Stopped” (Q 37) select “Not TB.” In the Comments field, state the reason why the case is no longer thought to be TB (e.g., Tuberculosis infection (TB2); M. avium; laboratory error).

Comments

In order for the Registry to maintain an accurate record of TB cases, and to identify the reason for submission of cases that turn out to be “Not TB,” it is necessary for jurisdictions to submit a new Follow-up 2 Report to the Registry any time there is a final disposition of “Not-TB.”

TB Registry Quality Control and TIMS Information

Quality Control in the TB Registry

The tuberculosis data in each local jurisdiction and in the state of California are most useful if the information entered into the system is valid, complete and timely. Listed below are several ways to ensure that the data you send to the state TB registry are of the highest possible quality. While not all jurisdictions will be able to fulfill all these steps for each case of TB, we highly recommend that you consider these issues when considering the operations of your TB case registry.

Tip: Several local TB programs have implemented a RVCT quality control practice by using these steps: 1) designate a local RVCT "expert"; 2) develop a written protocol outlining how the following activities will be carried out; 3) provide education on the RVCT and quality assurance practices to relevant staff; and 4) understand that this is an on-going practice to provide feedback to staff on successes as well areas for improvement.

Validity of the data

Much information is collected on each suspect and case of TB. This information may come from a variety of sources, including laboratories, public health nurses, private health care providers, disease investigators, etc.

Each variable on the Report of Verified case of Tuberculosis (RVCT) is designed to collect a specific piece of information on a TB case. It may be challenging for the person completing the RVCT (abstracting the information from the patient's chart) to correctly identify each of those bits of information when faced with multiple laboratory forms, repeat x-rays, etc. One way to address this is to assign a person other than the one completing the RVCT to compare the completed RVCT to the patient record.

Are the data logical?

The Tuberculosis Information Management Information System (TIMS) has many quality controls built into the software, including checks on logic. For example, an error message will be received during data entry if the data entry operator attempts to put drug susceptibility information (Q 33) into the Follow-up 1 screen when there is no positive culture identified in TIMS (Q18, Q20).

When entering Follow-up 1 and Follow-up 2 reports into TIMS it is important to review the entire RVCT to check for logical consistency with the new data being added. For example, a Follow-up 2 with the DOT field marked as "unknown" would be inconsistent with an RVCT indicating that the patient was dead at diagnosis. In this case, the DOT field should have been left blank. This error will need to be corrected.

Data entry fields marked as "unknown" or left blank should be investigated and corrections should be made when possible. Note that "unknown" should only be entered into those fields for which there is a true unknown. For example, if results for a culture are pending, the field should be left blank. The field should be filled in when results become available. Only if culture results have been lost or contaminated should the field be marked "unknown".

Data entry errors

One useful but often overlooked feature of TIMS is the Facsimile report generation. This report allows you to print out a hard copy of the RVCT data on a specific patient once it has been entered into your TIMS database. This copy can then be compared to the handwritten RVCT to identify data entry errors. If errors are found, corrections can be made before the data is transmitted to the state.

To generate a Facsimile report in TIMS:

1. Go to the TIMS Surveillance module.
2. Go to the pull down Report menu
3. Choose Facsimile.

Information: See the TIMS User's Guide, Appendix VII page VII-12 for more information (this is a hardcopy manual issued by the TB Registry to all LHJ TIMS users, if you do not have a copy, please contact the TB Registry).

Completeness of the data

In order for our TB data to be useful, all variables on all patients must have complete information reported. The RVCT and/or the Facsimile report should be checked for variables with missing information. Note that the Facsimile reports contain an asterisk next to the data field when there is missing information. If variables are found to have missing information, that data should be collected and entered into TIMS before transmission to the State.

Another useful report in TIMS is the Incomplete RVCT Records report. This report provides line listings of cases for which there is missing data. It is generally useful to print a copy of this report and reconcile missing data elements prior to transferring data to the state.

To generate an Incomplete RVCT Records report in TIMS:

1. Go to the TIMS Surveillance module.
2. Go to the pull down Report menu.
3. Choose Incomplete RVCT Records.

Information: See the TIMS User's Guide, Appendix VII page VII-11 for more information (this is a hardcopy manual issued by the TB Registry to all LHJ TIMS users, if you do not have a copy, please contact the TB Registry).

Quality control reports

Despite our best efforts, errors will happen! Part of the function of the State TB Registry is to pick up errors that may have slipped through, and to bring them to your attention. We also try to keep reporting timely by sending line listings of cases that may be due for a Follow-up 1 (Drug Susceptibility Report) or a Follow-up 2 (Case Completion Report).

Information: See TB Registry Quality Control Listings for a complete description of these reports, and how to respond to them.

TB Registry Quality Control Listings

The State TB Registry will periodically send to the local health jurisdictions (LHJ) several listings aimed at maintaining quality surveillance data on your TB cases. These listings should be used by LHJ personnel as an aid to completing or correcting RVCT surveillance data.

The listings are:

- A Type Errors
- B Type Errors
- Follow-up Record Check Reminder
- List of cases moved into your jurisdiction
- List of cases moved from your jurisdiction with a missing destination

A and B Type Errors

The A and B Type Error listings are for LHJ personnel to use to complete or correct their data. The A Type errors are very probable errors that should be checked very carefully, and corrected as necessary. The B Type errors are possible (though not probable) errors in your data – please check them, and correct as needed.

Follow-up Record Check Reminder

The Follow-up Record Check Reminder lists cases where the Follow-up 1 (FU-1) and/or the Follow-up 2 (FU-2) may be overdue. If a listed case is still on therapy, you may ignore it. We've attempted to list only those cases for which we feel an adequate length of time on therapy has passed. This list is simply a checklist for you and need not be returned to the state

Cases Reportedly Moved into your Jurisdiction

The Cases Reportedly Moved into your Jurisdiction lists cases that have moved to your jurisdiction from another California jurisdiction. You are responsible for submitting a FU-2 to the state for verified cases of TB that move into your jurisdiction. When the case meets any final outcome (e.g., completes therapy, dies, becomes lost, refuses treatment, etc.) please FAX these FU-2s to the state and not to the originating jurisdiction. When you have checked on each case that has reportedly moved into your jurisdiction, please FAX this listing back to the state with the current disposition of each case.

Beginning January 2003, cases that are not located in the destination jurisdiction after being reported as moved by the originating jurisdiction will be reclassified as "lost" in TIMS. See RVCT-Appendix II (RVCT and Case Completion (Follow-Up 2) Reporting

For Tuberculosis Patients that Move within California) (Tab 2) for complete reporting protocols for patients who move.

Reported Moved but No Destination Indicated

The Reported Moved but No Destination Indicated report lists cases that you've reported as moved but for which you gave no destination information. Please note on the listing where the case moved, so that the state can follow their progress while on therapy. Please FAX this listing back to the state when you've checked on each case.

ARPE (Aggregate Reports for Tuberculosis Program Evaluation)

ARPE

This topic provides report forms, reporting instructions, and information about the **Aggregate Reports for Tuberculosis Program Evaluation (ARPE)**.

About the ARPE reports

The **Aggregate Reports for Tuberculosis Program Evaluation** (ARPE) is an annual summary of the core activities of eliciting and evaluating contact to TB cases and treating the contacts who have latent TB infection.

There are two forms used in California to report contact investigation:

- **California Follow-up and Treatment for Contacts to TB Cases** (**CA ARPE-CI**): All LHJs are required to complete and submit the CA ARPE-CI **Preliminary** and **Final** report forms. Jurisdictions with no cases counted during the cohort period must still submit the forms reporting 0 (zero) for "Total TB Cases Reported" on both forms.

To obtain a copy of the ARPE forms, see TB Surveillance report forms – viewing and printing in the Welcome section of this document.

Frequently Asked Questions about ARPE Reports

ARPE-CI

What is the purpose of the ARPE-CI?

The purpose of the ARPE-CI is to assess the yield, efficiency, and effectiveness of TB program (local, state, national) contact investigation activities by collecting and calculating evaluation indices on these activities. Contact investigation activities are the first priority of TB control after case finding and treatment. It is important to measure performance and collect data for these activities to determine areas in which a TB program is doing well in and areas that require further effort. Program evaluation informs program planning and program activities.

Why did the ARPE-CI replace the Program Management Reports (PMRs, TB2 and TB5)?

The ARPE-CI replaced the PMRs (starting with July-December 1999 data in California) to better reflect current strategies of TB elimination. Formerly, contact investigation objectives (see reference 1) for which the PMRs collected data, focused on contacts categorized by age, i.e. above or below age 15. The ARPE-CI collects data for the following, current Centers of Disease Control and Prevention (CDC) contact investigation objectives2:

- Contacts will be identified for at least 90% of newly reported sputum AFBsmear positive TB cases.
- At least 95% of contacts to sputum AFB-smear positive TB cases will be evaluated for TB disease and latent TB infection (LTBI).
- At least 85% of infected contacts starting on treatment for LTBI will complete therapy. The primary change is that the new contact investigation objectives focus on contacts to the most infectious TB cases as opposed to focusing on contacts categorized by age. While you may still collect age-specific aggregate data for your program, it is no longer required for reporting to the California Department of Health Services (DHS) TB Control Branch (TBCB) or to CDC. The ARPE-CI also provides clearer definitions of data terms and simplifies the reporting process by keeping treatment outcomes on the same report form as contact identification and evaluation.

Why is there a California ARPE-CI?

In June 2000 the TBCB convened a workgroup made up of local health department representatives to further define ARPE definitions of ‘contact’ and ‘contact evaluated.’ This workgroup, dubbed the Contact Investigation Surveillance System Working Group (CISSWG), also recommended modifying the inclusion criteria for the ‘Others’ column on the CDC ARPE-CI. Under the proposed changes, this column would include contacts identified through investigations of pulmonary/laryngeal TB cases that

are neither sputum smear nor culture positive (see question #6 for examples of this new definition). The proposed changes were reviewed statewide and finalized in October 2000.

Unlike the CDC ARPE-CI, the California ARPE-CI (DHS 8635 A & B) does collect data on 'Cases for Investigation' and 'Cases with No Contacts' under the 'Other Pulmonary' column. The California ARPE-CI Preliminary Report form (DHS 8635 A) shades the rows that are not required. Please see Question 19 for a description of the Preliminary and Final (DHS 8635 B) forms. From here on, the California ARPE-CI will be referred to as the 'ARPE-CI' except when distinguishing it from the CDC ARPE-CI.

Contact Counts

Are only close contacts counted on the ARPE-CI?

Not necessarily. Persons exposed to a TB case who warrant evaluation for TB disease or latent infection, which may include both close and not close contacts, should be counted on the ARPE-CI. The California Department of Health Services (CDHS)/California TB Controllers Association (CTCA) Joint Guidelines on contact investigations defines types of contacts and describe recommended strategies for prioritizing and identifying contacts warranting evaluation. If, for example, the number of contacts is large enough, the concentric circle model may help determine which contacts warrant evaluation. Using this model, a health department calculates the ratio of evaluated close contacts with positive tuberculin skin tests (TSTs). If the ratio exceeds the expected infection prevalence, indicating likely recent transmission, the health department may decide to evaluate the next circle of 'not close' contacts. The close contacts and the 'not close' contacts which the health department decides need evaluation should be counted on the ARPE. Persons the health department determines do not need an evaluation, because evidence of transmission among more exposed contacts is low or because of limited exposure, should not be included on the ARPE.

How can one compare outcomes between jurisdictions using different definitions of a contact?

Comparing outcomes requires common definitions. In June 2000 CISSWG, a workgroup comprised of local health department representatives, met to further define the ARPE definitions of 'contact' and 'contact evaluated'. Their proposed changes were reviewed statewide and finalized in October 2000. Please refer to 'Basic Instructions for the California ARPE-CI' for the new definitions. Although these definitions are more specific, they still give local health departments flexibility to accommodate a variety of differences in defining contacts. The intention of the ARPE-CI is less to compare jurisdictions than it is to gather information on individual jurisdictions. Comparisons are not always appropriate because of differences in program resources and communities. Nonetheless, use of the ARPE-CI can promote dialog and thus improve understanding of the concepts and strategies surrounding contact investigation.

What are some examples of cases that belong in the 'Other Pulmonary' stratification? How is data in this column useful for TB control?

Pulmonary/laryngeal TB cases that are neither sputum smear positive nor sputum culture positive and contacts identified through investigations of these cases should be included in the 'Other Pulmonary' column. Examples of such cases include clinically diagnosed pulmonary cases and pediatric pulmonary TB cases diagnosed by gastric aspirate.

The inclusion criteria for the 'Other' column changed for California ARPE-CI data as a result of a process of reviewing and redefining key CDC ARPE-CI data elements proposed in June 2000 by a working group made up of local TB program representatives. The proposed changes were reviewed statewide and finalized in October 2000. Unlike the CDC ARPE-CI instructions, therefore, extrapulmonary cases and suspect TB patients who later rule out for TB will not be included on the California ARPE-CI. In August 2003, the California TB Controllers Association agreed to exclude source case investigations for all children regardless of disease type from the ARPE-CI.

Although the first two stratifications [sputum smear (+) and sputum smear (-), culture(+)] have a higher priority, it is also important to track evaluation and treatment results for contact investigations of other pulmonary cases counted in your jurisdiction. The ARPECI helps measure yield, efficiency, and effectiveness of these contact investigation activities.

How is evaluation and treatment for LTBI during the window period (time between 1st negative Tuberculin Skin Test (TST) and 2nd TST counted on the ARPE?

A contact is not considered fully evaluated until the final TST is placed and read and TB disease is ruled out. 'Started Treatment' and treatment outcomes (i.e. completed or reason not completed) refer to full-course treatment for LTBI (for example, 6-9 months of isoniazid), not treatment during the window period only. Thus patients on "window prophylaxis" would not be included as they have yet to be fully evaluated.

How are contacts with a history of prior positive TST counted on the ARPE-CI?

Contacts with prior positive TST can be counted under 'Evaluated' if they complete a medical evaluation. However, only LTBI or active TB that is diagnosed as a result of the current investigation is counted. A known history of LTBI is not counted as LTBI on the ARPE-CI even if they start treatment for LTBI as a result of the contact investigation. The ARPE-CI instructions refer to reporting treatment outcomes for contacts with a known history of LTBI on treatment under Part III of the other ARPE: Targeted Testing and Treatment for LTBI (ARPE-TT). Please note that only local health departments with CDC-funded targeted testing projects are required to complete the ARPE-TT at this time.

Where do we report 'Recent Tuberculin Converters (Non Contacts)' and 'Others With TB Infection' that were reported on the PMR TB5 Completion of Preventive Therapy report?

Although the PMR TB5 (now obsolete) allowed for reporting of recent TB converters (non-contacts) and others tested and treated for TB infection, this information is not collected on the ARPE-CI. Instead, this information is collected on the ARPE-TT. Again, in California, only local health departments with CDC-funded targeted testing projects are required to complete the ARPE-TT at this time.

How is the treatment of contacts with negative TST results, who are prescribed full course treatment for suspected LTBI, counted on the ARPE-CI?

In order to count their treatment outcomes and because a provider prescribed full treatment for suspected LTBI (for example, because of the potential for false-negative TST results), these contacts are counted as infected even though they have negative TSTs. For example, a provider for a contact taking immunosuppressive therapy suspects the contact is infected and prescribes full course treatment for LTBI. These contacts should be included under the following categories:

- Number of contacts,
- Evaluated,
- Latent TB Infection,
- Started Treatment (if started), and
- Treatment outcome (completed or reason not completed)

Under 'Reasons Treatment Not Completed', what is the difference between 'Contact Moved (follow-up unknown)' and 'Lost To Follow-Up'?

The 'Contact Moved (follow-up unknown)' treatment outcome is similar to the outcome 'Moved and records referred' on the PMR. Use this outcome when a contact moves to another jurisdiction with a locating address and no other specific outcome is documented. If the receiving jurisdiction reports a more specific outcome (for example, completed treatment) to the referring jurisdiction, then the referring jurisdiction can report that specific outcome on the ARPE-CI.

Please note that, if the contact moves to another jurisdiction, the referring jurisdiction should complete a California Confidential TB Referral Form and send it to the receiving jurisdiction. Unlike the Inter-jurisdictional Referral Desk for TB cases who move across jurisdictions, moves for contacts do not require the California Confidential TB Referral Form to be sent to TBCB. 'Lost To Follow-Up' is similar to the outcome 'Lost, unable to locate' on the PMR. Use this outcome when the contact cannot be found or when there was no forwarding address.

How are contacts identified in two related contact investigations counted?

If a contact is identified in two related contact investigations, for example, a secondary case is discovered in a contact investigation and another investigation begins, the contact should be counted only once during the calendar year. If, however, a contact is part of two unrelated contact investigations and the health department decides the contact needs a reevaluation, the contact should be counted twice.

How are contacts found during a source case investigation counted?

Unlike the CDC ARPE-CI where contacts in source case investigations are counted in the 'Others' column starting at 'Number of Contacts', source case investigations are excluded on the California ARPE-CI. However, if a source case is found, the source case's contact investigation should be counted on the ARPE-CI under the appropriate column (smear positive, smear negative, etc). In this situation, the index (pediatric) case may be counted as a contact to the source case.

Contact Investigations performed outside the Local Health Department

When a contact investigation is done at a work site or school, which contacts should be counted on the ARPE-CI?

Employees or students who warrant an evaluation for TB disease or latent infection because of exposure to an index case should count as contacts even if the number of contacts is large. Non-contacts, or persons who have probably not had significant exposure to the index case but who request inclusion in the contact investigation, should not be counted on the ARPE-CI. For example, persons tested only for public relations reasons or persons tested to decrease anxiety should not be counted as contacts on the ARPE-CI.

Do we need to collect and report data on the ARPE-CI for contact investigations managed by prisons or private providers?

Yes. Data from all contact investigations on cases counted in your jurisdiction should be reported on the ARPE-CI. CDC and TBCB encourage health department oversight of the evaluation and if recommended, treatment of all contacts to cases in your jurisdiction. To accomplish this, you may need to develop and/or strengthen communication links to collect contact data from providers outside your health department. ARPE reporting may help identify areas that need greater oversight and/or improved exchange of patient data and can document improved outcomes.

Should periodic testing, infection control, or surveillance testing in places of employment be counted on the ARPE-CI?

The ARPE-CI is not intended to collect information on periodic testing of employees unless the testing was specifically conducted for individuals who were known contacts to a case of infectious TB.

Should contact data be included in the ARPE-CI when the data is questionable?

The local health department should make every effort to ensure that their data on contact investigations is accurate. However, in situations where the health department cannot assure that the data are satisfactory, the data should not be included in the ARPE-CI. For example, if the health department receives data from a health care facility reporting an questionable number of contacts and the health department cannot verify, using the reporting definition, which contacts are actual contacts, then the index case and contacts should not be included in the ARPE-CI. In order to document and account for missing contact investigation data, it may be helpful to include a note explaining the situation with your ARPE submission to TBCB.

Which jurisdiction reports a contact if the case or contact is outside my local health jurisdiction?

The health department that counts a case also reports all contacts to that case. If your health department is evaluating and treating a contact exposed to a case outside your jurisdiction, your program should communicate the results of the evaluation and, if applicable, the results of treatment to the health department of the case's jurisdiction. If your jurisdiction counts the case and there are contacts managed in other jurisdictions, your program needs to inquire and collect results of the evaluation and, if applicable, results of treatment for those contacts. Cooperation and communication between health departments will help increase completeness and accuracy of contact reporting.

Reporting and Uses

When is the ARPE-CI due at TBCB and at CDC?

Please refer to the 'Schedule for Reporting Contacts to TB Cases in California'. The regular schedule for submitting the ARPE-CI to TBCB will follow the former PMR schedule. ARPE data are accumulated into half-year cohorts (i.e. January-June, July-December). Contacts are assigned to the cohort time period in which the index TB case to which the contact is linked was counted and reported to the State using the count date (variable #6 "Month-Year Counted" on the Report of Verified Case of TB).

Why are there Preliminary and Final ARPE-CI submissions?

Submission of the Preliminary Report (DHS 8635 A) allows for reporting of contact investigation data relatively close to the time of the investigation. This report contains the ARPE data from the top of the form through the 'Started Treatment' row (g1, g2, g), plus all of the Part II Evaluation Indices except for 'Completion Rate'. Since completion of treatment for LTBI may take a year or more, data for 'Completed Treatment' (h1, h2, h) and 'Reasons Treatment Not Completed' is reported in the Final Report (DHS 8635 B) a year after the Preliminary Report submission. The Final Report contains the previously submitted Preliminary Report data from the same cohort with any final corrections, the 'Completed Treatment' and 'Reasons Treatment Not Completed' rows, and 'Completion Rate' in Part II.

How can we keep track of the various ARPE-CI submissions?

To help keep track of the Preliminary and Final reports, you may want to keep all submitted ARPEs in a binder sorted by cohort. Then, when it is time to complete the final report, you will have records of the Preliminary report for the given cohort. To help with continuity in reporting techniques (for example, when there is staff turnover), you may want to document the steps taken to complete the ARPE and the program's perspective on reported numbers (for example, difficulties with obtaining outcomes from private providers contributing to the completion rate).

Will there be electronic reporting of the ARPE-CI using the TB Information Management System (TIMS)?

Currently, there are no plans for local health jurisdictions to electronically report the ARPE-CI using TIMS. One reason is because the CDC ARPE-CI is in TIMS and not the CA ARPE-CI which collects four additional data elements. The CA ARPE-CI should be submitted to TBCB via fax or mail.

Jurisdictions with TIMS are welcome to use TIMS for some of its ARPE functions. In TIMS, the Program Evaluation module, which contains the CDC ARPE-CI, allows for multiple screens of the ARPE form to be added together into a combined ARPE. This may be useful for keeping track of ARPE-CI data for each contact investigation when data is readily available. Then, when the ARPE is due to TBCB, the local health department can sum the individual ARPEs in TIMS for an aggregate report of a given cohort. This module also contains built-in quality control checks and will automatically calculate Part II. Evaluation Indices. Please note that TBCB does not provide technical support on this module.

What technical support is available for completing ARPE-CI?

A. Paper Trail

To assist local health departments with data organization on paper, the TBCB revised the contact roster in the CDHS/CTCA joint guidelines on contact investigations to collect ARPE-CI data. Also, the TBCB developed a data tallying tool to help categorize and count data needed to complete the ARPE-CI for each contact investigation. Finally, a checklist is available to assure accurate reporting for your completed ARPE-CI. These tools can be found under Tab 8 of the TBCB TB Registry Guidelines (poppy manual).

B. Computer software and databases

A number of local health departments have computer databases to track contact investigations. If you are interested in using a contact investigation database in your local health department, you may contact TBCB and the jurisdictions that have or are developing a contact investigation database to discuss options for your program.

The TBCB hopes to build on data systems already in place or in development. In Spring 2001, the TBCB plans to convene CISSWG again to discuss common data elements in contact databases used in California. CISSWG will continue to work toward facilitating the collection, analysis, and interpretation of contact investigation data.

How will the ARPE-CI be used?

The ARPE-CI data will be used to measure TB Indicators Project (TIP) contact investigation indicators. The ARPE-CI may be useful to all (TIP and non-TIP) local health departments in evaluation of their contact investigation activities for yield, efficiency, and effectiveness. Keep in mind that the quality and accuracy of reported data affect the evaluation of contact investigation activities. Manual calculation and reporting of these indices is required when using the CA ARPE Preliminary and Final reports. Local use of these indices to evaluate contact investigation activities is highly recommended.

The TBCB will regularly review the ARPE-CI data to determine how jurisdictions are performing in contact investigations. Data may indicate areas of strength and opportunities for improvement that need to be addressed on a statewide basis. The ARPE-CI data may help argue for increased resources for State and local health departments to improve contact investigations and will also inform TBCB's plans for future TB control and elimination efforts.

References

1. Former contact investigation objectives:

1. At least 95% of infectious suspects and confirmed TB cases will have contacts identified.

2. At least 95% of known contacts to infectious suspects and confirmed TB cases will receive examinations.

3. At least 95% of known infected contacts under 15 years of age will be placed on preventive therapy.

4. At least 75% of known infected contacts 15 years of age or older will be placed on preventive therapy.

5. At least 90% of known infected contacts under 15 years of age placed on preventive therapy will complete a minimum of six continuous months of preventive therapy.

6. At least 75% of known infected contacts 15 years of age or older placed on preventive therapy will complete a minimum of six continuous months of preventive therapy.

Adapted from 'Department of Health and Human Services Centers for Disease Control and Prevention. Announcement 700: TB Elimination Cooperative Agreements National TB Program Objectives, CY 1997. P. 10-11.'

2. Department of Health and Human Services Centers for Disease Control and Prevention. Announcement 00001: TB Elimination Cooperative Agreements National TB Program Objectives, CY 2000.

3. CDHS/CTCA. Contact Investigation Guidelines. 9/21/98.

A/B-Notification

A/B-Notification

This topic provides **A/B-Notification** report forms, reporting instructions, and information that you may download or access.

To obtain a copy of the A/B-Notification forms, see TB Surveillance report forms – viewing and printing in the Welcome section of this document.

About A/B Notification forms

Forms

There are two notification forms that California Local Health Jurisdictions (LHJs) send to the TBCB, as described below. To download the forms, click the appropriate link on the A/B Notification page.

- **B-Notification form (Class B Report on Alien with Tuberculosis (CDC 75.17)**: The B-Notification form is sent to the TBCB from a Local Health Jurisdiction who has received an immigrant alien classified with Class A Noncommunicable or Class B1 Not Infectious, TB.
- **Adverse Event form (A/B Tuberculosis Notification - Report of Adverse Event)**: If a Class B alien has an "adverse event" such as a relapse or a new diagnosis of TB, the LHJ sends a "Report of Adverse Event" to the TBCB.

Classifications for A/B Notification

- **Class A** (TB, Infectious)
- **Class A** (TB, Infectious, "Noncommunicable for travel purposes")
- **Class B** (TB, Clinically active, not infectious)
- **Class B2** (TB, Not clinically active, not infectious)

Frequently Asked Questions About the A/B-Notification Process

How long should I look for a B-notification patient before submitting the CDC 75.17 form to the state?

If a patient is not located within 30 days of arrival, you may check the "no show" box on the CDC 75.17 form and send the form to TBCB. No other documentation (e.g. CDC letter, medical records) needs to be sent to TBCB. If known, indicate on the form why the patient was not able to be located (e.g., "bad address", "patient died prior to locating").

Once a patient is located, how long do I have to complete their evaluation before I need to submit the CDC 75.17 form to TBCB?

Once a patient has been located, please retain the CDC 75.17 form until all variables are filled out. Do not submit forms with pending results.

What if the evaluation cannot be completed because the patient died?

If a patient dies before the evaluation is complete, the LHD should return the CDC 75.17 form to TBCB with all available evaluation results filled in, and a note stating, "Patient died prior to completing evaluation" on the form.

What if the patient moves before the evaluation is started or completed?

Moves within California

The LHD should forward the following directly to the destination LHD:

- Class B form - write the new address (street, city, state, zip code), phone number, and date moved on the Class B form.
- All corresponding medical records
- A completed National TB Controllers Association (NTCA) Interjurisdictional TB Notification form.

Send to the interjurisdictional contact person in the CTCA Roster. The NTCA Interjurisdictional Notification form can be found on-line at the TBCB website http://www.dhs.ca.gov/ps/dcdc/TBCB/resources.htm#transfercare.

Moves to another State

The LHD should forward the following to TBCB:

- Class B form - write the new address (street, city, state, zip code), phone number, and date moved on the Class B form.
- All corresponding medical records
- A completed NTCA Interjurisdictional TB Notification form.

TBCB will fax and mail the paperwork to the destination state (interjurisdictional contact person in NTCA Roster).

Moves to another country

The LHD should return the Class B form to TBCB, with the "no show" box checked, or evaluation results, if any, noting "Patient moved to [country]" on the form. Please send only the Class B form to TBCB. Do not include the patient's medical records or any other documentation.

What if a patient shows up without their medical records?

If your jurisdiction is the original immigration destination of the patient, but you have not received the medical evaluation and/or 75.17 form(s), contact the TBCB Registry (listed below), who will attempt to obtain the forms from the appropriate quarantine station. If your jurisdiction is not the original immigration destination of the patient, contact the original destination, if known, to have the forms forwarded to you.

If you don't know who to contact at the original jurisdiction, or if they are not able to supply the forms, contact the TBCB Registry (listed below) for further assistance. Use a facsimile CDC 75.17 form in the event that the original 75.17 is not obtainable. Write in the patient's Alien number, Name, Date of Birth and Address (with city, state and zip code), in addition to filling in the evaluation variables.

TB Registry A/B-Notifications: Phil Lowenthal, Epidemiologist (510) 620-3045

What if there are discrepancies between the overseas and U.S. medical exams?

The California Department of Health Services Tuberculosis Control Branch and the Centers for Disease Control and Prevention are interested in capturing and resolving problems with the A/B notification system. Use the "Report of Adverse Events" form to report adverse events to the TBCB following the protocol below. The TBCB should be notified as soon as possible following identification of an adverse event.

Examples of adverse events involving new arrivals with A/B notifications that should be reported to TBCB include:

- Presence of acid-fast bacilli on examination in the United States (U.S.)
- Identification of multi-drug resistant TB (MDR-TB) on evaluation of a newly arrived patient with class A/B notification
- Sub-optimal treatment regimens prior to entering the U.S.
- Significant discrepancies between the U.S. health department and the overseas examination or treatment history

When reporting these events, please include the following information:

- Statement of Problem
- Patient's full name, Alien number, and date of birth
- Results of overseas medical examination, including relevant worksheets (Medical Examination for Immigrant or Refugee Applicant, DS-2053; Medical Examination and Physical Examination Worksheet (DS-3026), Chest X-ray and Classification Worksheet, DS-3024)
- Date of U.S. entry
- Date and results of the U.S. examination
- Your name, title, phone number and e-mail address

Note: Please be aware that medical records may contain information about a patient's HIV status, as well as other confidential information. Therefore, when mailing reports of adverse events, please use the two-envelope procedure described below. The TBCB will forward the information to CDC's Division of Global Migration and Quarantine (DGMQ). DGMQ has committed to take steps to investigate and resolve these adverse events, and report results to TBCB, which we will then share with you.

What are the confidentiality requirements for transmitting Class B-notification patient information?

Class A/B notifications contain personal and medical information, including HIV status. Therefore, local and state health department staff must adhere to strict guidelines for maintaining the security and confidentiality of all Class A/B medical records. To ensure patient confidentiality when mailing Class A/B medical records to the TB Control Branch or to another jurisdiction, we suggest you use a two envelope procedure, which includes placing the medical records in an envelope, sealing it with tape, marking it "confidential", and addressing it to the specific authorized individual named above. The aforementioned envelope is placed inside another envelope with the appropriate address and name of the authorized person and sealed with tape. Please note that the outside envelope will not read "confidential."

Glossary

A

A/B Notification: A notification form sent to the TBCB from an Local Health Jurisdiction who has received an immigrant alien classified with Class A or Class B1 TB (typically Class B). See Glossary entries for Class A and Class B1 for more information.

ACET: Advisory Council for the Elimination of Tuberculosis

AFB: Acid-Fast Bacilli

AIDS: Acquired Immune Deficiency Syndrome

Alien: An "Alien" is defined by the Immigration and Naturalization Service (INS)4 as "anyperson not a citizen or national of the United States."

AM: Amikacin

ARPE: The "Aggregate Reports for Tuberculosis Program Evaluation" is an annual summary of the core activities of eliciting and evaluating contact to TB cases and treating the contacts who have latent TB infection. There are two forms used in California to report contact investigation: The "California ARPE Follow-up and Treatment for Contacts to TB Cases" (CA ARPE-CI), and the CDC ARPE "Targeted Testing and Treatment for Latent Tuberdculosis Infection" (ARPE-TT) (only LHJs with CDC-funded targeted testing projects in California are required to complete the ARPE-TT form).

ATS: American Thoracic Society

B

B-Notification: See "A-B Notification" glossary entry.

BCG: Bacilli Calmette-Guerin

Border crosser: A "Border crosser" is defined, in part, by the Immigration and Naturalization Service(INS) as "a nonresident alien entering the United States across the Mexican border for stays of no more than 72 hours." Border crossers may go back and forth across the border many times in a short period.

C

CAHAN: California Health Alert Network. CAHAN is a CDHS web-based system designed to broadcast warnings of impending or current disasters affecting the ability of health officials to provide disaster response services to the public. More information is available at: http://www.dhs.cahwnet.gov

CalPHIN: California Public Health Information Network. CALPHIN's goal is to provide timely and secure access to quality public health data for surveillance, analysis, and decision making, respecting the confidential nature of private information. California launched the CalPHIN initiative to provide an integrated public health information system to effectively serve the data needs of the local, state, and federal public health workforce and California's citizens. CalPHIN serves to integrate relevant health and disease information along with laboratory results and surveillance data from the many members of the State's public health system. See http://www.dhs.cahwnet.gov/ps/dcdc/nedss/default.htm

CAP: Caporeomycin

Case: An episode of TB disease in a person meeting the laboratory or clinical criteria for TB as defined in the document "Case Definitions for Infectious Conditions Under Public Health Surveillance."

Case, RVCT Report: A "Case" as applied to an RVCT Report, always includes the RVCT Report, and may include a Follow Up 1 and Follow Up 2 Reports, as appropriate. All three Reports have the same State and County Case numbers and comprise the entire case. Also see the clinical definition in the glossary entry for "Case".

CCTRF: California Confidential Tuberculosis Referral Form

CDC: The Centers for Disease Control and Prevention (CDC) is the lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. CDC, located in Atlanta, Georgia, USA, is an agency of the Department of Health and Human Services.

CDHS: CDHS is part of the California Health and Human Services Agency. The CDHS is one of the largest departments in State government, with over 5,000 employees working in its Sacramento headquarters and over 60 field offices throughout the State. As part of its mandate, the CDHS administers a broad range of public and clinical health programs that provide health care services to Californians.

CELDAR: California Electronic Laboratory Disease Alert and Reporting. A CDHS reporting system for laboratory-notifiable conditions. Public health, commercial, and veterinary laboratories will transmit lab results over the Internet to the CELDAR hub, and local health departments access the information there. The project is in the pilot-test phase.

Character Format: Keyboard letters, numbers, or special characters (such as a punctuation mark or $). Characters must be part of the standard (and/or extended) ASCII character set.

CHOW: Community Health Outreach Worker

CI: Contact Investigation (see the CI-Toolkit page in TB Registry Guidelines Help for contact investigation tools).

CI-Core Data Elements: A comparison of the data elements that were recommended by the CTCA/CDHS Joint Guidelines of 1998 and the data elements that are recommended by CDHS-TBCB in 2005 are presented in the Comparison Table of CI Data Elements table which you can download from the CI-Toolkit page.

CIP: Ciproflaxacin

Class 2: Latent TB infection, no evidence of current disease.

Class 3: Verified active TB disease; in the US these would be cases that meet the CDC verification definition.

Class 5: A suspected case of active TB disease.

Class A (TB, Infectious): Class A (TB, Infectious) is defined by the Division of Quarantine3 as an alien "with an abnormal chest radiograph or series of chest radiographs suggestive of current pulmonary TB and one or more positive sputum smear examinations for acid-fast bacilli." This person is not authorized to enter the United States unless a waiver has been granted (see definition for Class A - TB, Infectious, "Noncommunicable for travel purposes.")

Class A (TB, Infectious, "Noncommunicable for travel purposes"): Class A (TB, Infectious, "Noncommunicable for travel purposes") is defined by the Division of Quarantine3 as an alien "with an abnormal chest radiograph or series of chest radiographs suggestive of active TB, a history of one or more positive sputum smear examinations for acid-fast bacilli, currently on recommended treatment, and sputum smears that are negative for acid-fast bacilli on 3 consecutive days." This person is authorized to enter the United States if a waiver has been granted.

Class B1 (TB, clinically active, not infectious): Class B1 (TB, clinically active, not infectious) is defined by the Division of Quarantine as an alien "with an abnormal chest radiograph or series of chest radiographs suggestive of active TB, and sputum smears that are negative for acid-fast bacilli on 3 consecutive days." This person may be on anti-TB medications when entering the United States.

Class B2 (TB, Not clinically active, not infectious): Class B2 (TB, not clinically active, not infectious) Defined by the Division of Quarantine as an alien with an "abnormal chest x-ray suggestive of TB, not clinically active (e.g., fibrosis, scarring) and no initial sputum smears were required or initial smears were positive and three consecutive smears were negative after completion of a full course of treatment.

Cluster: A concentrated group of TB cases occurring within a specific location or time period. These cases may or may not be related, and therefore may or may not represent an outbreak of disease.

CMO: Chief Medical Officer

CMR: The Confidential Morbidity Report (CMR) is used to report certain suspected, lab-confirmed, and/or clinically diagnosed cases of communicable disease to local public health authorities.

Communicable disease: Any disease that may be transmitted directly or indirectly from one individual to another.

Contact: A person who has had "contact" with someone who has TB. All the following criteria must be met to count a person exposed to TB as a contact: The LHJ believes the person has been exposed; the exposure was caused by a TB case counted by the reporting jurisdiction; enough information is available to verify a current location or phone number for the named contact.

COT: Completion of Therapy

Counting of a TB case: The process whereby a reporting area with count authority evaluates verified TB cases(e.g., assesses for case duplication). These cases are then counted for morbidity in that locality (e.g., state or county) and reported to CDC for national morbidity counting.

CTCA: California Tuberculosis Controllers Association

Cx: Culture

CXR: Chest Radiograph

CYC: Cycloserine

D

DCDC: The Division of Communicable Disease Control (DCDC) works in partnership with local, national and international health officials, health care providers, and the public to monitor health, identify and investigate existing and potential health problems, develop and implement prevention strategies, conduct research, provide education and training, and formulate and advise on public health policy.

DOT: Directly Observed Therapy

DQ: Division of Global Migration and Quarantine. This is a division of the Centers for Disease Control (CDC) that is responsible for administering the A/B-notification process.

DTBE: Division of Tuberculosis Elimination (CDC)

Dx: Diagnosis

E

EMB: Ethambutol

EPTB: Extra-Pulmonary Tuberculosis

Error File: The Error file is a result of the Data Exchange XSLT validation process and shows specific variables that contain errors within an RVCT report.

ETH: Ethionamide

F

FDA: Food and Drug Administration

Follow Up 1: Follow Up 1 = Initial Drug Susceptibility Report: The Follow Up 1 form is part of the RVCT report (along with the RVCT form and the Follow Up 2 form) it contains Questions 33, 34 and a space for user Comments. Susceptibility results are collected on this form. You must complete this form for all patients who had a culture that was positive for Mycobacterium tuberculosis (M. tuberculosis) complex.

Follow Up 2: Follow Up 2 = Case Completion Report: The Follow Up 2 form is part of the RVCT report (along with the RVCT form and the Follow Up 1 form) it contains Questions 35 through 41 and a space for user comments. Treatment outcomes are collected on this form. Complete this form for all patients who were alive when TB was diagnosed.

FSIE: Food, Shelter, Incentives and Enablers

G

Genotyping: Using laboratory processes to describe the DNA pattern, or "fingerprint", of a particular TB strain. Genotyping is used to compare TB strains from different individuals to assess the possibility of transmission among them. If the strains are the same, recent transmission between these individuals is likely to have occurred. Restriction fragment length polymorphism (RFLP) is one genotyping method used.

H

HARS: HIV AIDS Registry System

HCW: Health Care Worker

High-risk population: A group of people who, by their medical or social characteristics, are at higher risk for TB infection and/or progression to TB disease if infected. Examples of high-risk groups include diabetics, HIV-positive individuals, and IV drug users. A list of risk categories can be found in the California Department of Health Services and California Tuberculosis Controllers Association Joint Guidelines for Tuberculosis Treatment and Control in California, "Targeted Skin Testing and Treatment of Latent Tuberculosis Infection in Adults and Children," pp. 3-4.

HIPAA: HIPAA Health Insurance Portability and Accountability Act of 1996. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of HIPAA, therefore HIPAA may mean different things to different people. HIPAA Health Insurance Reform: Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA Administrative Simplification: The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

HIV: Human Immunodeficiency Virus

HO: Health Officer

HTML: Hyper Text Mark-up Language. A structured document that is a collection of text, images and hyperlinks arranged and displayed to the user through a Web browser. Berners-Lee came up with the first set of HTML tags using a tag style defined by the OSI for their Standard Generalized Makup Language (SGML). The HTML standard is currently defined and controlled by the World Wide Web Consortium (W3C).

HTTP / HTTPS: The set of standards that defines how data are requested and transferred between server and client computers.

Hx: History

Hyperlink: Most commonly found on web pages, a link in the form of an icon, graphic or words that, when clicked, will transport the user to another file. The term was invented by Ted Nelson in 1965.

Hypervirulence: The characteristic of an infective organism that indicates a relatively greater than normal capacity to infect and/or cause disease. Certain strains of tuberculosis are known or thought to be hypervirulent, such as Strain W.

I

Index case: The first individual identified with active TB in the course of a TB contact or source case investigation.

INH: Isoniazid

Internet: The Internet is a network of more than 65 million computers in more than 100 countries covering commercial, academic and government endeavors. Originally developed for the U.S. military, the Internet became widely used for academic and commercial research. Users had access to unpublished data and journals on a huge variety of subjects. Today, the Internet has become commercialized into a worldwide information highway,providing information on every subject known to humankind.

Intranet: A variation of the word Internet, an intranet is a restricted-access network that works like the Web, but isn't on it. Usually owned and managed by a corporation, an intranet enables a company to share its resources with its employees without confidential information being made available to everyone with network access. An intranet is a private network, generally operating within an enterprise such as a corporation. Intranets are mostly closed to outside access, but operate with the same features and elements as public-network, Internet sites.

IOM: Institute of Medicine

IRD: Inter-jurisdictional Referral Desk

K

KAN: Kanamycin

L

LAB: Local Assistance Branch

LHD: Local Health Department (LHD). See the entry for LHJ (Local Health Jurisdiction) for details.

LHJ: Local Health Jurisdiction (LHJ). The "local" as opposed to "state" level health department. Each Jurisdiction has a specific code in California (see "California LHJ Codes" topic for a list of LHJs in California.) The term is sometimes used interchangeably with "Local Health Department," however "Jurisdiction" commonly refers to the geographical boundries of the health service, while "Department" refers to the service and staff within the Department. Local Health Jurisdiction (LHJ). (See "California LHJ Codes" in Appendix A for a list of LHJs in California.)

LTBI: Latent Tuberculosis Infection

M

MDL: Microbial Diseases Laboratory. The Microbial Diseases Laboratory at the CDHS provides reference, diagnostic, and applied research activities needed for method development and related laboratory services essential for the detection, epidemiological investigation, control, and prevention of diseases in humans, food, medical devices, and biologicals caused by bacteria, fungi, and parasites.

MDR / MDR TB: MDR Multi-drug Resistant. MDR TB Multi-drug Resistant Tuberculosis. This includes TB organisms that are resistant to both first-line drugs isoniazid (INH) and rifampin (RIF). The organism can be resistant to more drugs than just INH and RIF.

MTB: Mycobacterium Tuberculosis (also see "Mycobacterium tuberculosis complex."

MWWR: Morbidity and Mortality Weekly Report

Mycobacterium tuberculosis complex: Mycobacterium tuberculosis complex (M. tuberculosis complex) - consists of three mycobacterial species: M. tuberculosis, M. bovis, and M. africanum. These species are identical in DNA homology studies. In terms of their ability to cause clinical disease and to be transmissible from person to person, M. bovis and M. africanum behave like M. tuberculosis; therefore, disease caused by any of the three organisms should be reported as TB, using the Report of Verified Case of Tuberculosis (RVCT). The only exception is the BCG strain of M. bovis, which may be isolated from persons who have received the vaccine to protect against TB or as

cancer immunotherapy; disease caused by this M. bovis strain should not be reported as TB because the transmission is iatrogenic (treatment-induced), rather than person-to-person or communicable.

N

NEDSS: National Electronic Disease Surveillance System. CDC is implementing the National Electronic Disease Surveillance System (NEDSS) to better manage and enhance the large number of current surveillance systems and allow the public health community to respond more quickly to public health threats (e.g., outbreaks of emerging infectious diseases, bioterrorism, etc.). When completed, NEDSS will electronically integrate and link together a wide variety of surveillance activities and will facilitate more accurate and timely reporting of disease information to CDC and state and local health departments. Consistent with recommendations proffered in the 1995 report, Integrating Public Health Information and Surveillance Systems, NEDSS will include data standards, an internet based communications infrastructure built on industry standards, and policy-level agreements on data access, sharing, burden reduction, and protection of confidentiality. Online at: www.cdc.gov/od/hissb/act_int.htm.

Nontuberculous mycobacteria (NTM): Nontuberculous mycobacteria (NTM) - mycobacteria other than Mycobacterium tuberculosis complex that can cause human infection or disease. Common nontuberculous mycobacteria include M. avium complex or MAC (M. avium, M. intracellulare), M. kansasii, M. marinum,M. scrofulaceum, M. chelonae, M. fortuitum, and M. simiae. Other terms have been used to represent NTM, including MOTT (mycobacteria other than TB) and "atypical" mycobacteria.

NTCA: National Tuberculosis Controllers Association

NTM: NonTuberculous Mycobacteria

O

OFL: Ofloxacin

Online: Online as opposed to "offline". When you are working on the World Wide Web, you are "online." For example, when you access the internet and enter an RVCT form, you are entering the form "online."

Outbreak: The occurrence of newly identified cases of tuberculosis above the expected or baseline level, over a given time period, in a geographic area of facility, or in a specific population group. The number of TB cases comprising an outbreak will vary according to the size of the population exposed, the timeframe, and the place of occurrence.

P

PHN: Public Health Nurse

Phthisis TB: An early name for TB. Phthisis is a progressively wasting or consumptive condition; especially pulmonary tuberculosis. (From Greek, phthinein to waste away; akin to Sanskrit ksinoti he destroys.)

PMD: Private medical doctor

Polydrug resistance: A TB organism that is resistant to two or more tuberculosis drugs.

PPD: Purified Protein Derivative

PTB: Pulmonary Tuberculosis

PZA: Pyrazinamide

R

Registry: The TB Registery is the group with the CDHS-TBCB that controls the Surveillance reporting activities for California. The Registery receives surveillance reports from all California LHJs,

processes them, and then forwards the information to the Centers for Disease Control (CDC), as mandated by the CDC.

Report: 1): A form or series of forms used to enter and then submit mandated TB disease information to the TBCB, and then to the CDC, such as an RVCT or ARPE Report. 2): A data report generated and viewed (for example, a TIP report on the Tuberculosis Indicators Project website).

Reporting area: Areas responsible for counting and reporting verified TB cases to CDC. Currently there are 59 reporting areas; 50 states, District of Columbia, New York City, American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, Republic of Palau, and the U.S. Virgin Islands. Annual incidence of tuberculosis for the United States is based on 52 reporting areas (50 states, District of Columbia, and New York City).

RFB: Rifabutin

RHEIS: Refugee Health Electronic Information System

RIF: Rifampin

RM: Rifimate

RSHJ: Rural and Smaller Health Jurisdiction

RVCT: The Report Verified Case of Tuberculosis (RVCT) form is used by the CDC to collect specific TB surveillance data. All California health care providers are mandated to report to LHJs, within one day of diagnosis, all patients with suspected or confirmed TB (California Health and Safety Code sections 121361 and 121362). Providers use CMRs or locally developed TB CMRs to report suspected cases of TB to LHJs. The LHJs then submit RVCTs with specific information on the reportable cases of TB to the TBCB. The TBCB forwards the data on the reportable cases to the CDC.

Rx: Prescription

S

SAS: Statistical Analysis System

SAT: Self-Administered Therapy

Souce case investigation: The TB patient is under investigation as the source case in a possible outbreak or as the source for one or more "contact" cases.

STM: Streptomycin

Surveillance: Surveillance is a blanket term used to describe a set of public health activities that involve the reporting, tracking, analyzing and treating of communicable diseases, such as TB.

Suspect: A person for whom there is a high index of suspicion for active TB (e.g., a known contact to an active TB case or a person with signs/symptoms consistent with TB) who is currently under evaluation for TB disease.

Sx: Symptoms

T

TB (Tuberculosis): Tuberculosis (TB) is caused by an organism called Mycobacterium tuberculosis. When a person with active TB disease coughs or sneezes, tiny particles containing M. tuberculosis may be expelled into the air. If another person inhales air that contains these particles, transmission from one person to another may occur. However, not everyone infected with the TB germ becomes sick; as a result, two TB-related conditions exist: latent TB infection (LTBI) and active TB disease. Both LTBI and active TB are treatable and curable. A person with latent TB infection (LTBI): has TB germs in his/her body, but the germs are inactive; does not feel sick and is not contagious; has the potential to one day get sick if the TB germs become active and multiply in his/her body. A person with active TB disease: has active TB germs in his/her body; feels sick and experiences symptoms such as coughing, fever, and weight loss; is capable of spreading the disease to others if the TB germs are active in the lungs or throat.

TBCB: The Tuberculosis Control Branch (TBCB) is a branch of the CDHS Division of Communicable Disease Control (DCDC). The mission of the TBCB is to provide leadership and resources to control and eliminate tuberculosis and to speed the decline of TB morbidity and mortality. TB Surveillance data from Local Health Jurisdictions throughout California is forwarded to the TBCB, and from there to the CDC.

TBDS: Tuberculosis Database System

TBRN: Tuberculosis Refugee Notification

TBSDX: TB Surveillance Data Exchange (TBSDX) Specification outlining the electronic exchange of TB surveillance data (RVCT, Follow-up1, Follow-up2, ARPE-CI, ARPE-TT, B-Notification,..) from local health jurisdictions to TBCB.

TBX file: The TBX.XML file format is used to upload and submit TB Surveillance reports to the TBCB. The file may contain one or more surveillance reports, such as the RVCT, Follow Up 1, and Follow Up 2 reports.

Time of diagnosis: The date the first specimen was collected from the patient or, if no specimen was obtained, the date the first diagnostic test (e.g., chest x-ray) was performed. This applies even if the first specimen collected from the patient does not meet the laboratory criteria for disease. If no specimen was collected, and no diagnostic tests were done, the date treatment was started can be used as the time of diagnosis.

TIMS: Tuberculosis Information Management System. Tuberculosis Information Management System (TIMS) TIMS is a surveillance and case management software application developed by CDC used by TB control programs in all 50 states, the District of Columbia, and various U.S. territories. (To be replaced by the CDC NEDSS.)

TIP: Tuberculosis Indicator Project. TIP Reports are accessible on the TIP website http://www.tbdata.ca.gov/v2/portal/signon.asp.

TRIMS: Tuberculosis Registry Information Management System

TST: Tuberculin Skin Test

TU: Tuberculin Units

Tx: Treatment

U

Upload: Files are typically uploaded from a local computer system to a computer server that hosts the program that will receive the files.

URL: Uniform Resource Locator - A system for locating a website; generally in the form of http://www.websitename.com.

User Interface: The part of an application that the end user sees on the screen and works with to operate the application, such as menus, forms and "buttons."

Usual Residence: The place the patient was living at the time of diagnosis. This may be the place the patient receives mail (not a P.O. box), pays an electric bill, or considers to be his primary, stable residence in the U.S. The jurisdiction of a state, federal or military correctional facility where a patient was diagnosed with TB should be considered the usual residence of that case.

V

Validate: A procedure or protocol for valiging the values (data contents) of a form field, such as the fields in the RVCT or Follow-Up forms. For example, a "name" field may not allow number characters. If a user inadvertently entered a number in the "name" field, the validation program would display an error message informing the user that only alphabetical characters are acceptable in the field.

Verification of a TB case: The process whereby a TB case, after the diagnostic evaluation is complete, is reviewed at the local level (e.g., state or county) by a TB control official who is familiar

with TB surveillance definitions; if all the criteria for a TB case are met, the TB case is then verified and eligible for counting.

W

Web-based Application: A web-based application is designed from scratch to be accessed over the internet. Whereas, a web-enabled application is a non-web-based application that is made available on the web by means of other software/technology.

X

XML: Extensible Markup Language. XML is a markup language for documents containing structured information. Structured information contains both content (words, pictures, etc.) and some indication of what role that content plays (for example, content in a section heading has a different meaning from content in a footnote, which means something different than content in a figure caption or content in a database table, etc.) .Almost all documents have some structure. A markup language is a mechanism to identify structures in a document. The XML specification defines a standard way to add markup to documents.

XSD file: The TBX.XSD XML Schema Definition file is used for creating and validating the formation of the TBX.XML file which is used to transmit and submit surveillance data to the TBCB via data exchange

Appendix A – Codes Anatomic, County, LHJ, Country, Race

Note: For a complete cross-referenced list of anatomic codes you can download the new **Anatomic Codes Excel spreadsheet** from **TB Registry Guidelines Help**. The Help system is included on your TB Registry Guidelines CD or you can request it from the TB Registry at tbregistry@dhs.ca.gov.

Anatomic Codes for RVCT Questions Q 15 and Q 16

If you selected **80 Other** for **Q 15** and/or **Q 16** on the RVCT form, you must enter an **Anatomic Code** in the **Other** entry box (see Q15 Major Site of Disease and Q16 Additional Site of Disease).

Note: Just as anatomic code numbers are used on the RVCT form to identify sites of disease (00-Pulmonary, 10-Pleural, etc.), anatomic codes (such as 06-Blood, 28 Bronchial fluid, and 60-kidney) are also used to identify specific types of body tissue or fluid used for microscopic exam and/or culture analysis.

Requirements for entering anatomic codes in Q 15 and Q 16 "Other"

Sex specific: Certain anatomic codes must be specific to the Sex you have selected in Q 8 (Male or Female). Be sure you choose from the specific **Female** or **Male** lists shown below.

No duplications between Q 15 and Q 16: You cannot duplicate Other anatomic code entries for Q 15 and Q 16. For example, if you've selected 01 Subcutaneous Tissue for Q15 Other, you must select a different code for Q16 Other.

Female Anatomic Codes for Q 15 and/or Q 16 "Other"

00 Skin and Skin appendages

01 Subcutaneous Tissue

02 Breast

04 Bone Marrow

05 Spleen

06 Blood

18 Nose

19 Accessory Sinus

20 Nasopharynx

21 Epiglottis and Larynx

22 Trachea

30 Pericardium

31 Heart

32 Cardiac Valve

34 Blood Vessel

35 Mouth

36 Lip

37 Tongue

38 Tooth, Gum and Supporting Structures of the Tooth

39 Salivary Gland

40 Liver

41 Gallbladder

42 Extra hepatic Bile Duct

43 Pancreas
46 Pharynx, Oropharynx, and Hypopharynx
47 Tonsils and Adenoids
48 Esophagus
49 Stomach
50 Small Intestine - Duodenum
51 Small Intestine - Jejunum & Ileum
52 Appendix
53 Colon
54 Rectum
55 Anus
80 Placenta, Umbilical Cord, and Implantation Site
81 Fetus and Embryo
82 Pituitary Gland
83 Adrenal Gland
84 Thyroid or Parathyroid Gland(s)
85 Thymus
88 Brain
89 Spinal Cord
90 Cranial, Spinal and Peripheral Nerve
91 Eye and Ear Appendages
92 Ear and Mastoid Cells
94 Other

Male Anatomic Codes for Q 15 and/or Q 16 "Other"

00 Skin and Skin Appendages
01 Subcutaneous Tissue
02 Breast
04 Bone Marrow
05 Spleen
06 Blood
18 Nose
19 Accessory Sinus
20 Nasopharynx
21 Epiglottis and Larynx
22 Trachea
30 Pericardium
31 Heart
32 Cardiac Valve
34 Blood Vessel
35 Mouth
36 Lip
37 Tongue

38 Tooth, Gum and supporting Structures of the Tooth

39 Salivary Gland

40 Liver

41 GallBladder

42 Extrahepatic Bile Duct

43 Pancreas

46 Pharynx, Oropharynx, and Hypopharynx

47 Tonsils and Adenoids

48 Esophagus

49 Stomach

50 Small Intestine - Duodenum

51 Small Intestine - Jejunum & Ileum

52 Appendix

53 Colon

54 Rectum

55 Anus

82 Pituitary Gland

83 Adrenal Gland

84 Thyroid or Parathyroid Gland(s)

85 Thymus

88 Brain

89 Spinal Cord

90 Cranial, Spinal and Peripheral Nerve

91 Eye and Ear Appendages

92 Ear and Mastoid Cells

94 Other

Anatomic Codes for RVCT Questions Q 19 and Q 20

You must enter Anatomic Code(s) if you selected "Positive" for Q 19 and/or Q 20 on the RVCT form. (See Q 19 Microscopic Exam of Tissue / Other Body Fluids and Q 20 Culture of Tissue and Other Body Fluids.)

Note: For a complete cross-referenced list of anatomic codes you can download the new **Anatomic Codes Excel spreadsheet** from **TB Registry Guidelines Help**. The Help system is included on your TB Registry Guidelines CD or you can request it from the TB Registry at tbregistry@dhs.ca.gov.

Requirements for entering anatomic codes in Q 19 and Q 20

Positive must be selected: Enter code(s) in Q 19 and/or Q 20 only if you have selected the Postive option for the question.

One or two codes are Ok: There are two entry boxes for anatomic codes in both Q 19 (19b and 19c) and Q 20 (20b and 20c). You may enter one code in each entry box as appropriate (you are not required to enter more than one code, however if you enter only one code, be sure that you enter it in the top entry box [19b or 20b].)

Site specific: The anatomic codes you enter must be specific for selections in both the Major Site of Disease in Q 15 and for Additional Sites of Disease Q 16. For example, if you have selected 00-Pulmonary in Q 15 and you have also selected 10 Pleural and 40 Genitourinary in Q 16, you can only select anatomic codes from the Pulmonary, Pleural, and Genitourinary sites.

Sex specific: Certain anatomic codes for 40-Genitourinary, 50-Miliary, and 80-Other must be specific to the Sex you have selected in Q 8 (Male or Female). If you are choosing anatomic codes form 40, 50, or 80, be sure you choose from the specific Male or Female list.

Anatomic Codes

00 Pulmonary

06 Blood

07 Lymph node

23 Bronchus

24 Bronchiole

25 Lung

28 Bronchial fluid

56 Gastric aspirate

57 Gastrointestinal contents (feces)

93 Pus

99 Unknown

10 Pleural

06 Blood

07 Lymph node

26 Pleura

29 Pleural fluid

93 Pus

99 Unknown

21 Lymphatic: Cervical

06 Blood

07 Lymph node

93 Pus

99 Unknown

22 Lymphatic: Intrathoracic

06 Blood

07 Lymph node

93 Pus

99 Unknown

23 Lymphatic: Other

06 Blood

07 Lymph node

93 Pus

99 Unknown

29 Lymphatic: Unknown

06 Blood

07 Lymph node

93 Pus

99 Unknown

30 Bone and/or Joint

06 Blood

07 Lymph node

08 Bone (not otherwise specified)

09 Skeletal system (bones of head, rib cage, and vertebral column)

10 Skeletal system (bones of shoulder, girdle, pelvis, and extremities)

11 Soft tissue (not otherwise specified)

12 Soft tissue (muscles of head, neck, mouth and upper extremity)

13 Soft tissue (muscles of trunk, perineum, and lower extremity)

14 Tendon and tendon sheath

15 Ligament and fascia

16 Joints (synovial tissue)

17 Synovial fluid

93 Pus

99 Unknown

40 Genitourinary

If Sex=1 (Male), valid Codes are:

06 Blood

07 Lymph node

60 Kidney

61 Renal pelvis

62 Ureter

63 Urinary bladder

64 Urethra

65 Penis

66 Prostate and seminal vesicle

67 Testis

68 Epididymis, vas deferens, spermatic cord and scrotum

69 Urine

70 Male genital fluids

93 Pus

99 Unknown

If Sex=2 (Female), valid Codes are:

06 Blood

07 Lymph node

60 Kidney

61 Renal pelvis

62 Ureter

63 Urinary bladder

64 Urethra

69 Urine

71 Vulva, labia, clitoris, and Bartholin's gland

72 Vagina

73 Uterus

74 Cervix

75 Endometrium

76 Myometrium

77 Fallopian tube, broad ligament, parametrium, and paraovarian region

78 Ovary

79 Female genital fluids

93 Pus

99 Unknown

50 Miliary

If Sex=1 (Male), valid Codes are:

00 Skin and skin appendages

01 Subcutaneous tissue

02 Breast

04 Bone marrow

05 Spleen

06 Blood

07 Lymph node

08 Bone (not otherwise specified)

09 Skeletal system (bones of head, rib cage, and vertebral column)

10 Skeletal system (bones of shoulder, girdle, pelvis, and extremities)

11 Soft tissue (not otherwise specified)

12 Soft tissue (muscles of head, neck, mouth and upper extremity)

13 Soft tissue (muscles of trunk, perineum, and lower extremity)

14 Tendon and tendon sheath

15 Ligament and fascia

16 Joints (synovial tissue)
17 Synovial fluid
18 Nose
19 Accessory sinus
20 Nasopharynx
21 Epiglottis and larynx
22 Trachea
23 Bronchus
24 Bronchiole
25 Lung
26 Pleura
27 Upper respiratory fluids
28 Bronchial fluid
29 Pleural fluid
30 Pericardium
31 Heart
32 Cardiac valve
33 Pericardial fluid
34 Blood vessel
35 Mouth
36 Lip
37 Tongue
38 Tooth, gum and supporting structures of the tooth
39 Salivary gland
40 Liver
41 Gallbladder
42 Extrahepatic bile duct
43 Pancreas
44 Saliva
45 Bile and pancreatic fluid
46 Pharynx, oropharynx, and hypopharynx
47 Tonsils and adenoids
48 Esophagus
49 Stomach
50 Small intestine - duodenum
51 Small intestine - jejunum & ileum
52 Appendix
53 Colon
54 Rectum
55 Anus
56 Gastric aspirate
57 Gastrointestinal contents (feces)
58 Omentum and peritoneum

59 Peritoneal fluid
60 Kidney
61 Renal pelvis
62 Ureter
63 Urinary bladder
64 Urethra
65 Penis
66 Prostate and seminal vesicle
67 Testis
68 Epididymis, vas deferens, spermatic cord and scrotum
69 Urine
70 Male genital fluids
82 Pituitary gland
83 Adrenal gland
84 Thyroid or parathyroid gland(s)
85 Thymus
86 CSF (cerebrospinal fluid)
87 Meninges, dural sinus, choroid plexus
88 Brain
89 Spinal cord
90 Cranial, spinal and peripheral nerve
91 Eye and ear appendages
92 Ear and mastoid cells
93 Pus
94 Other
95 Multiple sites
99 Unknown

If Sex=2 (Female), valid Codes are:

00 Skin and skin appendages
01 Subcutaneous tissue
02 Breast
03 Milk
04 Bone marrow
05 Spleen
06 Blood
07 Lymph node
08 Bone (not otherwise specified)
09 Skeletal system (bones of head, rib cage, and vertebral column)
10 Skeletal system (bones of shoulder, girdle, pelvis, and extremities)
11 Soft tissue (not otherwise specified)
12 Soft tissue (muscles of head, neck, mouth and upper extremity)
13 Soft tissue (muscles of trunk, perineum, and lower extremity)
14 Tendon and tendon sheath

15 Ligament and fascia
16 Joints (synovial tissue)
17 Synovial fluid
18 Nose
19 Accessory sinus
20 Nasopharynx
21 Epiglottis and larynx
22 Trachea
23 Bronchus
24 Bronchiole
25 Lung
26 Pleura
27 Upper respiratory fluids
28 Bronchial fluid
29 Pleural fluid
30 Pericardium
31 Heart
32 Cardiac valve
33 Pericardial fluid
34 Blood vessel
35 Mouth
36 Lip
37 Tongue
38 Tooth, gum and supporting structures of the tooth
39 Salivary gland
40 Liver
41 Gallbladder
42 Extrahepatic bile duct
43 Pancreas
44 Saliva
45 Bile and pancreatic fluid
46 Pharynx, oropharynx, and hypopharynx
47 Tonsils and adenoids
48 Esophagus
49 Stomach
50 Small intestine - duodenum
51 Small intestine - jejunum & ileum
52 Appendix
53 Colon
54 Rectum
55 Anus
56 Gastric aspirate
57 Gastrointestinal contents (feces)

58 Omentum and peritoneum
59 Peritoneal fluid
60 Kidney
61 Renal pelvis
62 Ureter
63 Urinary bladder
64 Urethra
69 Urine
71 Vulva, labia, clitoris, and Bartholin's gland
72 Vagina
73 Uterus
74 Cervix
75 Endometrium
76 Myometrium
77 Fallopian tube, broad ligament, parametrium, and paraovarian region
78 Ovary
79 Female genital fluids
80 Placenta, umbilical cord, and implantation site
81 Fetus and embryo
82 Pituitary gland
83 Adrenal gland
84 Thyroid or parathyroid gland(s)
85 Thymus
86 CSF (cerebrospinal fluid)
87 Meninges, dural sinus, choroid plexus
88 Brain
89 Spinal cord
90 Cranial, spinal and peripheral nerve
91 Eye and ear appendages
92 Ear and mastoid cells
93 Pus
94 Other
95 Multiple sites
99 Unknown

60 Meningeal

06 Blood
07 Lymph node
86 CSF (cerebrospinal fluid)
87 Meninges, dural sinus, choroid plexus
93 Pus
99 Unknown

70 Peritoneal

06 Blood

07 Lymph node

58 Omentum and peritoneum

59 Peritoneal fluid

93 Pus

99 Unknown

80 Other

If Sex=1 (Male), valid Codes are those entered in Q.15b or Q.16b (i.e., one or two Codes from the following list):

00 Skin and skin appendages

01 Subcutaneous tissue

02 Breast

04 Bone marrow

05 Spleen

06 Blood

18 Nose

19 Accessory sinus

20 Nasopharynx

21 Epiglottis and larynx

22 Trachea

30 Pericardium

31 Heart

32 Cardiac valve

34 Blood vessel

35 Mouth

36 Lip

37 Tongue

38 Tooth, gum and supporting structures of the tooth

39 Salivary gland

40 Liver

41 Gallbladder

42 Extrahepatic bile duct

43 Pancreas

46 Pharynx, oropharynx, and hypopharynx

47 Tonsils and adenoids

48 Esophagus

49 Stomach

50 Small intestine - duodenum

51 Small intestine - jejunum & ileum

52 Appendix

53 Colon

54 Rectum

55 Anus

82 Pituitary gland

83 Adrenal gland

84 Thyroid or parathyroid gland(s)

85 Thymus

88 Brain

89 Spinal cord

90 Cranial, spinal and peripheral nerve

91 Eye and ear appendages

92 Ear and mastoid cells

94 Other

and the following:

If an Anatomic Code in Q.15b or Q.16b is equal to 18, 19, or 20, then also allow:

27 Upper respiratory fluids.

If an Anatomic Code in Q.15b or Q.16b is equal to 30 or 31, then also allow:

33 Pericardial fluid.

If an Anatomic Code in Q.15b or Q.16b is equal to 35, 36, 37, 38, or 39, then also allow:

44 Saliva.

If an Anatomic Code in Q.15b or Q.16b is equal to 40, 41, 42, or 43, then also allow:

45 Bile and pancreatic fluid.

If an Anatomic Code in Q.15b or Q.16b is equal to 18, 19, 20, 21, 22, 35, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 48, 49, or 50, then also allow:

56 Gastric aspirate.

If an Anatomic Code in Q.15b or Q.16b is equal to 18, 19, 20, 21, 22, 35, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 48, 49, 50, 51, 52, 53, 54, or 55, then also allow:

57 Gastrointestinal contents (feces).

If Sex=2 (Female), valid Codes are those entered in Q.15b or Q.16b (i.e., one or two from the following list):

00 Skin and skin appendages

01 Subcutaneous tissue

02 Breast

04 Bone marrow

05 Spleen

06 Blood

18 Nose

19 Accessory sinus

20 Nasopharynx

21 Epiglottis and larynx

22 Trachea

30 Pericardium

31 Heart

32 Cardiac valve

34 Blood vessel

35 Mouth

36 Lip

37 Tongue

38 Tooth, gum and supporting structures of the tooth

39 Salivary gland

40 Liver

41 Gallbladder

42 Extrahepatic bile duct

43 Pancreas

46 Pharynx, oropharynx, and hypopharynx

47 Tonsils and adenoids

48 Esophagus

49 Stomach

50 Small intestine - duodenum

51 Small intestine - jejunum & ileum

52 Appendix

53 Colon

54 Rectum

55 Anus

80 Placenta, umbilical cord, and implantation site

81 Fetus and embryo

82 Pituitary gland

83 Adrenal gland

84 Thyroid or parathyroid gland(s)

85 Thymus

88 Brain

89 Spinal cord

90 Cranial, spinal and peripheral nerve

91 Eye and ear appendages

92 Ear and mastoid cells

94 Other

and the following:

If an Anatomic Code in Q.15b or Q.16b is equal to 18, 19, or 20, then also allow:

27 Upper respiratory fluids .

If an Anatomic Code in Q.15b or Q.16b is equal to 30 or 31, then also allow:

33 Pericardial fluid.

If an Anatomic Code in Q.15b or Q.16b is equal to 35, 36, 37, 38, or 39, then also allow:

44 Saliva.

If an Anatomic Code in Q.15b or Q.16b is equal to 40, 41, 42, or 43, then also allow:

45 Bile and pancreatic fluid.

If an Anatomic Code in Q.15b or Q.16b is equal to 18, 19, 20, 21, 22, 35, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 48, 49, or 50, then also allow:

56 Gastric aspirate.

California County Codes

Note: The following codes are the official Federal Information Processing Standards (**FIPS**) codes (website at http://www.census.gov/geo/www/fips/fips.html).

001 Alameda

003 Alpine

005 Amador

007 Butte

009 Calaveras

011 Colusa

013 Contra Costa

015 Del Norte

017 El Dorado

019 Fresno

021 Glenn

023 Humboldt

025 Imperial

027 Inyo

029 Kern

031 Kings

033 Lake

035 Lassen

037 Los Angeles

039 Madera

041 Marin

043 Mariposa

045 Mendocino

047 Merced

049 Modoc

051 Mono

053 Monterey

055 Napa

057 Nevada

059 Orange

061 Placer

063 Plumas

065 Riverside

067 Sacramento

069 San Benito

071 San Bernardino

073 San Diego

075 San Franciscogo

077 San Joaquin

079 San Luis Obispo

081 San Mateo

083 Santa Barbara

085 Santa Clara

087 Santa Cruz

089 Shasta

091 Sierra

093 Siskiyou

095 Solano

097 Sonoma

099 Stanislaus

101 Sutter

103 Tehama

105 Trinity

107 Tulare

109 Tuolumne

111 Ventura

113 Yolo

115 Yuba

California Local Health Jurisdiction (LHJ) Codes

Use the following codes to identify specific Local Health Jurisdictions (LHJs) in California.

60	**alameda**	**30**	**orange**
02	**alpine**	**76**	**pasadena City**
03	**Amador**	**31**	**placer**
65	**berkeley City**	**32**	**plumas**
04	**butte**	**33**	**riverside**
05	**calaveras**	**34**	**sacramento**
06	**colusa**	**35**	**san benito**
07	**contra costa**	**36**	**san bernardino**
08	**del norte**	**80**	**san diego**
09	**el dorado**	**90**	**san francisco**
10	**fresno**	**39**	**san joaquin**
11	**glenn**	**40**	**san luis obispo**
12	**humboldt**	**41**	**san mateo**
13	**imperial**	**42**	**santa barbara**
14	**inyo**	**43**	**santa clara**
15	**kern**	**44**	**santa cruz**
16	**kings**	**45**	**shasta**

17	**lake**	**46**	**sierra**
18	**lassen**	**47**	**siskiyou**
75	**long beach City**	**48**	**solano**
70	**los angeles**	**49**	**sonoma**
20	**madera**	**50**	**stanislaus**
21	**marin**	**51**	**sutter**
22	**mariposa**	**52**	**tehama**
23	**mendocino**	**53**	**trinity**
24	**merced**	**54**	**tulare**
25	**modoc**	**55**	**tuolumne**
26	**mono**	**56**	**ventura**
27	**monterey**	**79**	**vernon City**
28	**napa**	**57**	**yolo**
29	**nevada**	**58**	**yuba**

Country Code List

Country	Alpha Code	FIPS Code
A		
Afghanistan	**AF**	110
Albania	**AL**	120
Algeria	**AG**	125
American Samoa	**AQ**	060
Andorra	**AN**	140
Angola	**AO**	141
Anguilla	**AV**	142
Antarctica	**AY**	143
Antigua and Barbuda	**AC**	149
Argentina	**AR**	150
Armenia	**AM**	135
Aruba	**AA**	100
Ashmore and Cartier Islands	**AT**	155
Australia	**AS**	160
Austria	**AU**	165
Azerbaijan	**AJ**	115
B		
Bahamas, The	**BF**	180
Bahrain	**BA**	181
Baker Island	**FQ**	064
Bangladesh	**BG**	182
Barbados	**BB**	184
Bassas Da India	**BS**	187
Belarus	**BO**	211

Belgium	**BE**	190
Belize	**BH**	227
Benin	**BN**	311
Bermuda	**BD**	195
Bhutan	**BT**	200
Bolivia	**BL**	205
Bosnia and Hercegovina	**BK**	185
Botswana	**BC**	210
Bouvet Island	**BV**	212
Brazil	**BR**	220
British Indian Ocean Territories	**IO**	228
British Virgin Islands	**VI**	231
Brunei	**BX**	232
Bulgaria	**BU**	245
Burkina (Upper Volta)	**UV**	927
Burma	**BM**	250
Burundi	**BY**	252
C		
Cambodia	**CB**	255
Cameroon	**CM**	257
Canada	**CA**	260
Cape Verde	**CV**	264
Cayman Islands	**CJ**	268
Central African Republic	**CT**	269
Chad	**CD**	273
Chile	**CI**	275
China	**CH**	280
Christmas Island	**KT**	516
Clipperton Island	**IP**	282

Cocos (Keeling) Islands	**CK**	284
Colombia	**CO**	285
Comoros	**CN**	286
Congo	**CF**	290
Cook Islands	**CW**	293
Coral Sea Islands	**CR**	294
Costa Rica	**CS**	295
Croatia	**HR**	440
Cuba	**CU**	300
Cyprus	**CY**	305
Czech Republic	**EZ**	310
Czechoslovakia	**CZ**	310
D		
Denmark	**DA**	315
Djibouti	**DJ**	317
Dominica	**DO**	318
Dominican Republic	**DR**	320
E		
Ecuador	**EC**	325
Egypt	**EG**	922
El Salvador	**ES**	330
Equatorial Guinea	**EK**	332
Estonia	**EN**	331
Ethiopia	**ET**	335
Europa Island	**EU**	334
F		
Falkland (Is Malvinas)	**FK**	337
Faroe Islands	**FO**	336

Fed States Micronesia	**FM**	063
Fiji	**FJ**	338
Finland	**FI**	340
Fr So & Antarctic Lands	**FS**	369
France	**FR**	350
French Guiana	**FG**	355
French Polynesia	**FP**	367
G		
Gabon	**GB**	388
Gambia, The	**GA**	389
Gaza Strip	**GZ**	393
Georgia	**GG**	390
Germany	**GM**	394
Ghana	**GH**	396
Gibraltar	**GI**	397
Glorioso Islands	**GO**	399
Greece	**GR**	400
Greenland	**GL**	405
Grenada	**GJ**	406
Guadeloupe	**GP**	407
Guam	**GU**	066
Guatemala	**GT**	415
Guernsey	**GK**	416
Guinea	**GV**	417
Guinea-Bissau	**PU**	737
Guyana	**GY**	418
H		
Haiti	**HA**	420

Heard Island & McDonald Islands	**HM**	424
Honduras	**HO**	430
Hong Kong	**HK**	435
Howland Island	**HQ**	065
Hungary	**HU**	445
I		
Iceland	**IC**	450
India	**IN**	455
Indonesia	**ID**	458
Iran	**IR**	460
Iraq	**IZ**	465
Iraq-S Arabia Neutral Zone	**IY**	467
Ireland	**EI**	470
Israel	**IS**	475
Italy	**IT**	480
Ivory Coast	**IV**	485
J		
Jamaica	**JM**	487
Jan Mayen	**JN**	488
Japan	**JA**	490
Jarvis Island	**DQ**	062
Jersey	**JE**	495
Johnston Atoll	**JQ**	067
Jordan	**JO**	500
Juan De Nova Island	**JU**	497
K		
Kazakhstan	**KZ**	525

Kenya	**KE**	505
Kingman Reef	**KQ**	068
Kiribati	**KR**	398
Korea, South	**KS**	515
Korea, North	**KN**	514
Kuwait	**KU**	520
Kyrgyzstan	**KG**	510
L		
Laos	**LA**	530
Latvia	**LG**	541
Lebanon	**LE**	540
Lesotho	**LT**	543
Liberia	**LI**	545
Libya	**LY**	550
Liechtenstein	**LS**	553
Lithuania	**LH**	542
Luxembourg	**LU**	570
M		
Macau	**MC**	573
Macedonia	**MK**	574
Madagascar	**MA**	575
Malawi	**MI**	577
Malaysia	**MY**	580
Maldives	**MV**	583
Mali	**ML**	585
Malta	**MT**	590
Man	**IM**	588
Marshall Islands	**RM**	073

Martinique	**MB**	591
Mauritania	**MR**	592
Mauritius	**MP**	593
Mayotte	**MF**	594
Mexico	**MX**	595
Midway Island	**MQ**	071
Moldova	**MD**	576
Monaco	**MN**	607
Mongolia	**MG**	608
Montenegro	**MW**	612
Montserrat	**MH**	609
Morocco	**MO**	610
Mozambique	**MZ**	615
N		
Namibia	**WA**	821
Nauru	**NR**	621
Navassa Island	**BQ**	061
Nepal	**NP**	625
Netherlands	**NL**	630
Netherlands Antilles	**NT**	640
New Caledonia	**NC**	645
New Zealand	**NZ**	660
Nicaragua	**NU**	665
Niger	**NG**	667
Nigeria	**NI**	670
Niue	**NE**	672
Norfolk Island	**NF**	683
Northern Mariana Island	**CQ**	069
Norway	**NO**	685

Not Specified	***99***	*999*
O		
Oman	**MU**	616
P		
Pakistan	**PK**	700
Palmyra Atoll	**LQ**	070
Panama	**PM**	710
Papua New Guinea	**PP**	712
Paracel Islands	**PF**	714
Paraguay	**PA**	715
Peru	**PE**	720
Philippines	**RP**	725
Pitcairn Islands	**PC**	727
Poland	**PL**	730
Portugal	**PO**	735
Portuguese Timor	**PT**	738
Puerto Rico	**RQ**	001
Q		
Qatar	**QA**	747
R		
Reunion	**RE**	750
Romania	**RO**	755
Russia	**RS**	825
Rwanda	**RW**	758

S		
S.Georgia/S.Sandwich Islands	**SX**	953
San Marino	**SM**	782
Sao Tome and Principe	**TP**	783
Saudi Arabia	**SA**	785
Senegal	**SG**	787
Serbia	**SR**	810
Seychelles	**SE**	788
Sierra Leone	**SL**	790
Singapore	**SN**	795
Slovak Republic	**LO**	548
Slovenia	**SI**	789
Solomon Islands	**BP**	229
Somalia	**SO**	800
South Africa	**SF**	801
Soviet Union	**UR**	825
Spain	**SP**	830
Spratly Islands	**PG**	833
Sri Lanka	**CE**	272
St. Lucia	**ST**	770
St. Helena	**SH**	765
St. Kitts and Nevis	**SC**	763
St. Pierre and Miquelon	**SB**	773
St. Vincent/Grenadines	**VC**	775
Sudan	**SU**	835
Suriname	**NS**	840
Svalbard	**SV**	845
Swaziland	**WZ**	847
Sweden	**SW**	850

Switzerland	**SZ**	855
Syria	**SY**	858
T		
Taiwan	**TW**	281
Tajikistan	**TI**	784
Tanzania	**TZ**	865
Thailand	**TH**	875
Togo	**TO**	883
Tokelau	**TL**	884
Tonga	**TN**	886
Trinidad and Tobago	**TD**	887
Tromelin Island	**TE**	889
Trust Territories Of Pacific	**PS**	075
Tunisia	**TS**	890
Turkey	**TU**	905
Turkmenistan	**TX**	909
Turks and Caicos Islands	**TK**	906
Tuvalu	**TV**	908
U		
U.S. Minor Outlying Islands	**UM**	074
US Misc Pacific Islands	**IQ**	077
Uganda	**UG**	910
Ukraine	**UP**	928
United Arab Emirates	**TC**	888
United Kingdom	**UK**	925
Uruguay	**UY**	930
Uzbekistan	**UZ**	931
Unknown	***99***	*999*

V		
Vanuatu (New Hebrides)1	**NH**	651
Vatican City	**VT**	934
Venezuela	**VE**	940
Vietnam	**VM**	945
Virgin Islands	**VQ**	078
W		
Wake Island	**WQ**	080
Wallis and Futuna	**WF**	950
West Bank	**WE**	955
Western Sahara	**WI**	831
Western Samoa	**WS**	963
X		
Yemen	**YM**	965
Yugoslavia	**YO**	970
Y		
No entries exist for this letter		
Z		
Zaire	**CG**	291
Zambia	**ZA**	990
Zimbabwe	**ZI**	818

Race Specify Codes (HL7) for Q 09

If required for Question 09 Race, the appropriate HL7 extended codes, below, should be entered in the Specify boxes for either Asian or Native Hawaiian or Pacific Islander.

ASIAN Extended HL7 Codes	**Native Hawaiian or Pacific Islander Extended HL7 Codes**
2028-9 Asian	2076-8 Native Hawaiian other Pacific Islander
2029-7 Asian Indian	2078-4 Polynesian
2030-5 Bangladeshi	2079-2 Native Hawaiian
2031-3 Bhutanese	2080-0 Samoan
2032-1 Burmese	2081-8 Tahitian
2033-9 Cambodian	2082-6 Tongan
2034-7 Chinese	2083-4 Tokelauan
2035-4 Taiwanese	2085-9 Micronesian
2036-2 Filipino	2086-7 Guamanian or Chamorro
2037-0 Hmong	2087-5 Guamanian
2038-8 Indonesian	2083-3 Chamorro
2039-6 Japanese	2089-1 Mariana Islander
2040-4 Korean	2090-9 Marshalles
2041-2 Laotian	2091-7 Palauan
2042-0 Malaysian	2092-5 Carolinian
2043-8 Okinawan	2093-3 Kosraean
2044-6 Pakistani	2094-1 Pohnpeian
2045-3 Sri Lankan	2095-8 Saipanese
2046-1 Thai	2096-6 Kiribati
2047-9 Vietnamese	2097-4 Chuukese
2048-7 Iwo Jiman	2098-2 Yapese
2049-5 Maldivian	2100-6 Melanesian
2050-3 Nepalese	2101-4 Fijian
2051-1 Singaporean	2102-2 Papua New Guinean
2052-9 Madagascar	2103-0 Solomon Islander
	2104-8 New Hebrides
	2500-7 Other Pacific Islander